Universidade do Minho
Escola de Psicologia

Inês Ramos Sá Mendes

Innovative moments and narrative change in emotion-focused therapy and client-centered therapy

Outubro de 2010

Innovative moments and narrative change in emotion-focused therapy and client-centered therapy
Inês Ramos Sá Mendes
UMinho | 2010

Universidade do Minho
Escola de Psicologia

Inês Ramos Sá Mendes

Innovative moments and narrative change in emotion-focused therapy and client-centered therapy

Tese de Doutoramento em Psicologia
Área de Conhecimento em Psicologia Clínica

Trabalho efectuado sob a orientação do
Professor Doutor Miguel M. Gonçalves

Outubro de 2010

À memória do meu pai.

AGRADECIMENTOS

Neste percurso de desenvolvimento do meu doutoramento, que compreendeu quatro anos da minha vida, muitos são os que caminharam a meu lado! Contudo, destacarei aqueles que tiveram maior relevância e influência directa na execução da presente dissertação.

Em primeiro lugar, quero agradecer ao meu orientador Professor Doutor Miguel Gonçalves pela oportunidade de uma aprendizagem de excelência, pela revigorante e inspiradora curiosidade científica, pelos constantes e persistentes desafios (até de mim mesma) e pela sua perseverança (até em mim mesma).

À Professora Lynne Angus agradeço o amável acolhimento na minha deslocação à Universidade de York, o questionamento pertinente sobre os resultados deste estudo que ainda ecoa em mim.

Ao Professor Luis Botella pela constante disponibilidade e apoio no período de estudos na Universidade Ramon Llull.

Um agradecimento muito especial aos *MIs*, a minha equipa de trabalho, ao longo destes anos. Agradeço profundamente o espírito de entreajuda, a cumplicidade, a paciência… por alegrarem cada dia de trabalho e reuniões. O meu agradecimento muito especial ao António Ribeiro e à Carla Cunha pela disponibilidade em ouvir as minhas dúvidas, inseguranças e angústias, pelo constante apoio, ânimo e confiança.

Às "*minhas*" "*tão queridas*"amigas Joana Silva, Joana Coutinho e Vânia Lima agradeço, principalmente, as gargalhadas inesquecíveis, por tantas vezes me terem feito chorar de alegria. Esses momentos serão sempre uma das mais gratificantes memórias associadas a este processo.

À Ara Nuñez, Raquel Mesquita e Rodrigo Lopes, preciosas amizades que nascem no âmbito deste doutoramento, muito obrigada pelas infindáveis conversas e pelos entusiásticos momentos de partilha.

À minha mãe e à minha irmã o meu mais profundo agradecimento e, porque palavras não são suficientes, permito-me apenas citar o nosso poeta: "Mais uma vez e SEMPRE!".

À minha família pela união e pelo apoio incondicional.

Aos meus amigos agradeço todos os momentos de partilha, todos os sorrisos e gargalhadas, por me acompanharem em tantas aventuras que vão colorindo "o meu pequeno mundo". Pelos tantos capítulos, paralelos a esta dissertação, que escrevemos e que enriquecem a minha história de vida.

A todos, com todo o carinho, o meu MUITO OBRIGADA!

Este projecto foi financiado pela Fundação para a Ciência e Tecnologia (FCT), através da atribuição da Bolsa de Doutoramento com a referência SFRH/BD/29804/2006.

MOMENTOS DE INOVAÇÃO E MUDANÇA NARRATIVA EM TERAPIA FOCADA EM EMOÇÕES E TERAPIA CENTRADA NO CLIENTE

RESUMO

Os Momentos de Inovação (ou MIs) constituem novidades narrativas que representam uma nova forma de pensar, sentir ou agir que representam experiências não congruentes com a narrativa problemática (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010). O conceito de MIs, surgido inicialmente no contexto da terapia narrativa (TN; White & Epston, 1990), foi desenvolvido por Gonçalves e colaboradores (2009) num estudo que permitiu a distinção de cinco tipos – acção, reflexão, protesto, reconceptualização e desempenho da mudança. Posteriormente, o desenvolvimento do Sistema de Codificação dos Momentos de Inovação (SCMI; Gonçalves, Ribeiro, et al., 2010), veio permitir a identificação destas novidades narrativas em psicoterapia. Numa fase inicial, este sistema de codificação foi utilizado num estudo com dez mulheres vítimas de violência na intimidade, seguidas em TN (Matos, Santos, Gonçalves, & Martins, 2009). A análise de dois grupos terapêuticos contrastantes - um com sucesso e outro com insucesso terapêutico - demonstraram uma elevada presença de MIs no grupo com sucesso terapêutico, particularmente de MIs de reconceptualização e desempenho da mudança. O grupo com insucesso terapêutico apresentou menor presença de MIs, sendo caracterizado fundamentalmente por MIs de acção, reflexão e protesto. Com base nos resultados deste primeiro estudo com o SCMI, foi proposto um modelo de mudança narrativa caracterizado pela emergência de MIs de acção, reflexão e protesto numa fase inicial da terapia, seguido pela emergência de MIs de reconceptualização e desempenho da mudança durante a fase intermédia e revelando uma tendência crescente destes MIs até ao final da terapia (Matos et al., 2009).

A presente dissertação surge da necessidade de expandir a investigação em torno do SCMI a diferentes modelos terapêuticos e diferentes problemáticas. Deste modo, um dos objectivos principais deste trabalho consiste em perceber se o SCMI se constitui um método adequado para identificar novidades narrativas em modalidades psicoterapêuticas distintas do modelo original. Assim, primeiramente, aplicamos o SCMI a um caso de sucesso

terapêutico em terapia focada em emoções (TFE) e percebemos que, para além do SCMI ser aplicável a um modelo terapêutico e a uma problemática distintos, também o padrão desenvolvimental dos MIs é semelhante ao encontrado no grupo com sucesso terapêutico da TN.

Os dois estudos seguintes da presente dissertação envolvem a análise de duas amostras clínicas, uma de TFE e outra de terapia centrada no cliente (TCC). Globalmente, foram seguidos os propósitos do primeiro estudo: 1) a aplicação do SCMI a modalidades terapêuticas distintas da TN; e 2) o estudo do padrão desenvolvimental dos MIs nos grupos contrastantes de sucesso e insucesso terapêutico. Na generalidade, os principais resultados destes estudos evidenciam a existência de valores significativamente superiores de MIs nos grupos de sucesso terapêutico quando comparados com os grupos com insucesso terapêutico. Em particular, os MIs de reconceptualização e desempenho da mudança distinguem os dois grupos terapêuticos, sendo quase inexistente nos grupos com insucesso. Estes resultados são semelhantes aos encontrados com a TN e, por isso, vêm fornecer um maior apoio empírico ao SCMI, apresentando-o como um método adequado para identificar MIs em diversas modalidades psicoterapêuticas. Simultaneamente, estes resultados também apoiam o modelo narrativo de mudança, que realça o importante papel dos MIs de reconceptualização e desempenho da mudança numa evolução bem-sucedida do processo terapêutico.

O quarto e último estudo que compõe esta dissertação compreende um desenvolvimento progressivo do SCMI. A amostra de TFE foi analisada segundo os subtipos (I e II) de MIs de reflexão e protesto que surgem no primeiro capítulo. Neste estudo, verifica-se que os MIs de reflexão subtipo II, e os MIs de protesto subtipo II apresentam-se de forma significativamente mais elevada no grupo de sucesso terapêutico, conduzindo à hipótese de se constituírem como promotores de MIs de reconceptualização.

INNOVATIVE MOMENTS AND NARRATIVE CHANGE IN EMOTION-FOCUSED THERAPY AND CLIENT- CENTERED THERAPY

ABSTRACT

Innovative moments (or IMs) are narrative novelties that constitute a different way of thinking, feeling and behaving from the problematic self-narrative (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010). The concept of IMs emerged within the narrative framework (White & Epston, 1990). Gonçalves and colleagues (2009) developed a study in which they distinguished five different types of IMs – action, reflection, protest, re-conceptualization and performing change and developed the Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, et al., 2010), to be able to identify these narrative novelties in psychotherapy. This methodological tool was applied to ten cases of women of intimate violence followed in narrative therapy (NT; Matos, Santos, Gonçalves, & Martins, 2009). The analysis with the IMCS showed a higher presence of IMs in the good outcome group and also a higher proportion of two specific IMs types – re-conceptualization and performing change. The poor outcome group presented lower IMs, being action, reflection and protest the main IMs types present in this group. Based on the findings of this study the authors proposed a heuristic model of narrative change characterized by action, reflection and protest IMs in the beginning of therapy and by the emergence of re-conceptualization IMs during the middle phase with an increasing trend towards termination (Matos et al., 2009). Performing change IMs emerge, also during the intermediate stage and increases until the end of therapy.

This dissertation emerges from the need of following the analyses with the IMCS in different therapeutic modalities and different clinical problematic. One of our main purposes is to find if the IMCS can constitute a reliable tool to track narrative novelties

in psychotherapy. Specially, if we consider that this coding system was developed within NT and we could only hypothesize its applicability to therapeutic models that don't consider the exceptions to the problem to be their goal. Firstly, we applied the IMCS to a good outcome case of emotion-focused therapy (EFT) and found that besides the reliable applicability of the IMCs to a different therapeutic model and to a different clinical problematic, also the developmental pattern of IMs was similar to the one found in the good outcome group of NT.

The two following studies in this dissertation involved the analysis of two clinical samples of humanistic based therapies, one EFT and one client-centered therapy (CCT). Globally we pursued the same purposes of the first study – 1) the applicability of the IMCS; and the developmental pattern of IMs in good outcome group and poor outcome group. The main findings of these analyses consisted in the higher presence of IMs in the good outcome group when compared with the poor outcome group. Re-conceptualization and performing change IMs distinguished the two outcome groups being almost absent in the poor outcome group. These results are similar to the ones found in the NT sample supporting the IMCS as a reliable methodological tool to identify IMs in psychotherapy and also the narrative model of change, highlighting the role of re-conceptualization and performing change in successful psychotherapy.

The fourth and last study that composes this dissertation regards the further development of the IMCS. The EFT sample was analyzed according to reflection and protest IMs subtypes (I and II) that emerged in the first chapter. The subtypes II of both reflection and protest IMs were significantly higher in the good outcome group leading to hypothesize their possible role as promoters of re-conceptualization IMs.

TABLE OF CONTENTS

TABLES

FIGURES

INTRODUCTION

INTRODUCTION

"*Self-making is a narrative art*" (Bruner, 2004, p.4). This statement constitutes the starting point of my doctoral dissertation. As psychotherapists we all want to understand how human change is constructed; to understand our clients' meaning-making processes that foster their "*self-making narratives*" (Bruner, 2004, p.4). Since we, as human beings, construct and re-construct ourselves through narrative, how can we facilitate our clients to construct an alternative life story from the one they brought to therapy?

As the perspective of common factors suggests there are some elements present in all forms of psychotherapy (Duncan, Miller, Wampold, & Hubble, 2010). One of these elements involves the telling and retelling of stories within the therapeutic context (Angus & McLeod, 2004). The stories we tell ourselves and the others (including the therapist within the context of psychotherapy) embody hopes, intentions, dreams and goals. Culture has its influence in the "repertoire of life stories" (Polkinghorne, 2004, p. 53) restricting the interpretations people attribute to the situations they experience in their lives. These limiting interpretations can narrow their understating of themselves, others and the world. In this sense, when clients enter therapy they bring a problematic self-narrative that is constraining their lives. In psychotherapy, therapists and clients work together, not only in the reduction of symptoms and suffering, but often also in the transformation of the client's problematic self-narrative (Botella, Herrero, Pacheco, & Corbella, 2004). As McLeod pointed out "What changes in therapy is not the symptoms but the stories told by the person." (2004, p. 362). Problematic self-narratives emerge when individuals are unable to integrate conflicts and the world's complexities, constraining the way they perceive and organize their view of themselves, others and the world they live in. Self-narrative transformation is made possible by the integration

of new events in clients' self-narrative and also by a revaluation of the former ones. These new events are considered by White and Epston (1990) unique outcomes or exceptions to the problematic self-narrative and they constitute new opportunities for the client to expand their constraining interpretations of themselves and the world, being able to elaborate new meanings and re-construct a new self-narrative. In the narrative tradition, therapeutic change entails the (re)construction of the clients' self-narrative through the re-authoring of their life stories.

In the present dissertation our main goal is to identify the novelties that depict the process of therapeutic change and understand their role in the (re)construction of a new self-narrative. These novelties are denominated in this dissertation as innovative moments (or IMs) (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Matos, Santos, Gonçalves, & Martins, 2009; Santos, Gonçalves, Matos, & Salvatore, 2009; Ribeiro, Gonçalves, & Santos, in press).

The notion of IMs is inspired in the concept of unique outcomes from White and Epston (1990), defined as exceptions towards a problematic self-narrative. Thus, IMs are all the occurrences in therapy in which the client describes or narrates him or herself differently than one would expect from the perspective of the problem that brought him or her into therapy. These could emerge in different forms, as a thought, a plan, a feeling, an action; that falls outside the influence of the *rules* of the problematic self-narrative that organizes the client's life. Thus, if the problematic self-narrative is the rule (e.g. lack of assertiveness), IMs are all the exceptions to this rule (e.g. "I have the right to express myself, whether the others like it or not."); all those times that the client experiences or narrates something that, implicitly or explicitly, challenges or rejects the problematic self-narrative that has been shaping his or her life.

Departing from a conceptual narrative framework Gonçalves and colleagues (2009) claimed the "*heterogeneous nature*" (p.7) of the IMs distinguishing five different types - action, reflection, protest, re-conceptualization and performing change (Appendix I). These authors intended to study the therapeutic process of change through the analysis of the emergence of the different types of IMs developing a coding system to track these narrative novelties. The Innovative Moments Coding System (IMCS) (Gonçalves, Ribeiro, et al., 2010) is a systematic, reliable method for the identification of IMs that are the narrative changes emerging within and across psychotherapy sessions.

A pioneering study was conducted to explore the role of the IMs in therapeutic process (Matos et al., 2009). This study involved a sample of ten cases of women victims of intimate violence drawn from narrative therapy (NT) and they were analyzed with the IMCS. Since White and Epston (1990) claimed that unique outcomes constitute new windows for re-authoring conversations and a preferred self-narrative, one of the research questions guiding Matos and colleagues research was if more IMs would emerge in the good outcome group. Other research questions concerning this pioneering study entailed if different types emerge differently in the good and the poor outcome groups and if different types would be more specific of different therapeutic phases. The results indicated that IMs appeared in both good and poor outcome groups. However, clients in the good outcome group, when compared to the poor outcome group, spent significantly more time in the sessions elaborating IMs (evaluated by the time clients and therapists spend describing and talking about the IM), specifically re-conceptualization and performing change IMs. These two latter types of IMs presented significant statistical differences between the two outcome groups while no significant differences were found between the two outcome groups in relation to action, reflection and protest IMs. In the good outcome group re-conceptualization and performing

change IMs emerged in the middle phase of therapy and continue to increase through final phase. In the poor outcome group these two types are almost absent. From these results, it was hypothesized that re-conceptualization and performing change IMs may be necessary for client self-narrative change to occur.

From this first study with the IMCS a model of narrative change in psychotherapy was suggested by the authors. According to this model, action and reflection IMs are usually the first ones to emerge in the therapeutic conversation and they represent new events and new thoughts that are not predicted by the problematic self-narrative. These types of IMs are very important at the beginning because they demonstrate that something different from the problem is being elaborated (Gonçalves et al., 2009).

Protest IMs represent the client confrontation and refusal of the demands and assumptions of the problematic self-narrative, and this rejection enables the client to reposition him or herself towards the problem and the others that supports it, assuming a position of assertiveness and agency in the process of self re-construction.

Re-conceptualization is a more complex type of IMs because it requires a further narrative elaboration of the novelties that are emerging in the form of the previous types of IMs. The articulation of these novelties allows the client to be aware of what he or she used to be when dominated by the problem (White & Epston, 1990), how he or she is now when giving voice to a new emerging self and the process that took place between one position to the other. It is as if the client could see him or herself changing through a meta-reflective position allowing an authorship position regarding the change process and the new self-narrative.

Performing change is the performance of the gains that the client is engaged in when he or she further expands the process of change.

From the previous study of the IMs in NT emerges this dissertation which aims to further the study of the process of narrative change with the IMCS in different therapeutic models and with different populations. We wanted to investigate if the five types of IMs found in the study conducted by Matos and colleagues (2009) would also emerge in a therapeutic model outside the narrative tradition, especially one that doesn't consider the exceptions to the problem as a goal of the therapeutic process. The first chapter presents a study that consists in our first attempt to apply the IMCS to another therapeutic model – emotion-focused therapy (EFT) - with one good outcome case of a patient with depression, also a different clinical population than the one studied by Matos and colleagues (2009). EFT therapists are more concerned with emotional experiencing and processing in order to facilitate the access, identification and the restructuring of problematic emotion schemes (Greenberg & Watson, 2006), as opposed to narrative therapists that intentionally search for exceptions to the problem (or IMs). Therefore, the aim of this first study is to investigate the emergence of IMs and narrative change in one EFT case.

After realizing the applicability of the IMCS to a good outcome case we investigate the emergence of IMs in an EFT sample from the York I Depression Study (Greenberg & Watson, 1998) (Chapter II). This sample consisted in 3 good and 3 poor outcome cases. We wanted to understand if the pattern found in the good outcome cases would replicate in other good outcome cases and what would be the pattern of IMs in the poor outcome group. Would we find differences between the outcome groups? Would they converge with the findings of NT, presenting higher proportion of IMs in the good outcome group and with re-conceptualization and performing change IMs presenting a significantly higher presence in the good outcome group? Since IMCS was inspired in

NT (White & Epston, 1990) this study remains a test of IMCS' applicability to other therapeutic modalities.

Chapter III presents our continuing pursuit of evidence to the applicability of the IMCS to other therapeutic models. Hence, we conducted another study which intended to describe the narrative process of change in client-centered therapy (CCT) and to compare the results obtained in this sample with a sample of EFT, both from the York I Depression Study (Greenberg & Watson, 1998). The study of IMs' development in CCT was one of our main purposes and also the comparison between EFT and CCT. These two therapeutic modalities follow the same fundamental relational conditions regarding the therapeutic relationship and its importance in the therapeutic work. Besides this client-centered relational attitudes, EFT also integrates gestalt and experiential interventions (e.g., two-chair dialogues, empty-chair dialogue, systematic evocative unfolding, focusing) (Elliott, et al., 2004). Since these two samples belong to the York I Depression Study (same clinical population, same site, same therapists, and same central therapeutic principles) we were curious about the major differences and similarities between these samples regarding the IMs' development. We hypothesized that the general IMs' pattern in CCT would be similar to the one found in EFT (chapter II) and NT (Matos, et al., 2009).

As we proceeded in this research project we realized that the previous studies with the IMCS in clinical samples (NT, EFT and CCT) have disregarded the role of action, reflection and protest IMs in the construction of a new self-narrative. These three types of IMs do not present significant differences between outcome groups but they are the most common types all along the therapeutic process in poor outcome cases and the most common in the initial and middle phase of therapy in good outcome cases. Namely, reflection and protest are very common in several modalities of therapy

(Gonçalves, Santos, et al., 2010; Matos et al., 2009) and they precede the elaboration of re-conceptualization in good outcome cases. So, we conducted our final study (chapter IV) with the intention of analyzing the role of these IMs types in the change process. How reflection and protest IMs evolve in good and poor outcome cases? Are there any differences on a more qualitative level despite the absence of differences on a quantitative level between good and poor outcome cases? We considered the EFT sample as our starting point to conduct this analysis since the single case-study (chapter I) shed light on the potential role of reflection and protest IMs.

The reader may find some redundancy throughout this thesis since each chapter starts with a brief IMs' definition, its methodological tool – IMCS – and the heuristic model of narrative change developed from the studies conducted with the IMCS. This is due to the format of the dissertation, being each chapter an autonomous paper.

CHAPTER I

INNOVATIVE MOMENTS AND CHANGE IN EMOTION-FOCUSED THERAPY: THE CASE OF LISA

CHAPTER I

INNOVATIVE MOMENTS AND CHANGE IN EMOTION-FOCUSED THERAPY: THE CASE OF LISA[1]

1. ABSTRACT

This article presents an intensive analysis of a good outcome case of emotion-focused therapy – the case of Lisa – using the *Innovative Moments Coding System* (IMCS). The IMCS, influenced by White's narrative therapy, conceptualizes narrative change as resulting from the elaboration and expansion of narrative exceptions or *unique outcomes* to a client's core problematic self-narrative. The IMCS identifies and tracks the occurrence of 5 different types of narrative change: *action*, *reflection*, *protest*, *re-conceptualization*, and *performing change*. This is the first attempt to use the IMCS with cases outside the narrative tradition. We discuss the results, emphasizing the commonalities and major differences between this case and other good outcome cases.

2. INTRODUCTION

In this article, we report findings emerging from the intensive case analysis of Lisa, one of the most successful cases from the York I Project on Depression Study (Greenberg & Watson, 1998; Greenberg & Angus 1994), using the *Innovative Moments Coding System* (IMCS; Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010). The IMCS is grounded in a narrative tradition and this is the first application of the IMCS with a therapeutic approach not based in this tradition, allowing us to test the applicability of this coding system to other models of therapy. The main purpose of this study is to assess whether the application of the IMCS can

[1] This work is in press in the *Journal of Constructivist Psychology*, in co-authorship with Miguel M. Gonçalves, Inês Mendes, Antonio P. Ribeiro, Lynne E. Angus and Leslie S. Greenberg.

facilitate a richer, theoretical understanding of how client change occurs in EFT of depression.

The IMCS (Gonçalves et al., 2009; Gonçalves, Ribeiro, et al., 2010) is rooted in a narrative conception of the self, as it was conceptually elaborated by Bruner (1986), McAdams (1993) and Sarbin (1986), among others (see also Angus & McLeod, 2004; Gonçalves & Machado, 1999; Hermans & Hermans-Jansen, 1995). At the core of these theoretical contributions is the notion that human beings construct meanings for their lives by narrating episodes about themselves, others, and the world. This cognitive construction of narrative structures allows us to organize our identity by constructing an integrated life-story (see Habermas & Bluck, 2000; McAdams, 2001a, b).

As McAdams (2001a) suggests, a self-narrative constructed, for instance, from the theme of agency (e.g., self-mastery) would be very different than one constructed from the theme of communion (e.g., love, dialogue). These two themes might shape very different lives, organizing people's relationships, behaviors, thoughts, goals, and emotions very differently.

The IMCS (Gonçalves et al., 2009; Gonçalves, Ribeiro, et al., 2010) provides a systematic, reliable method for the identification of narrative changes emerging within and across psychotherapy sessions. This method was inspired by the work of White and Epston (1990), who suggested that client's self-narrative change can occur when positive outcome stories, or what they call *unique outcome stories*, are accessed and elaborated in the therapeutic conversation. From this perspective, change does not take place because a problematic self-narrative is somehow "corrected" and the client is free to elaborate new meanings, but rather clients elaborate new meanings in therapy (that is, unique outcomes) and the accumulation of new meanings allows them to revise the problematic self-narrative (see White, 2007 for a description of therapeutic techniques).

In this framework, problematic self-narratives are accounts of the person, others, and the world that impose strict constraints in the construction of meanings, making it difficult for the person to elaborate the diversity of daily life. The relevant point here is that if a problematic self-narrative makes the client unable to capture the diversity of lived experience, many experiences will be ignored and neglected. These neglected or ignored experiences are what White and Epston (1990) call unique outcomes. For instance, depressive clients often tell self-narratives around the themes of loss, inability, and hopelessness (see research on the prototypical narratives of different psychopathological categories, Gonçalves & Machado, 1999). The dominance of this self-narrative is the result of neglecting and ignoring unique outcomes, which are episodes in which the person felt, thought, or behaved in a non-depressive way. For instance, in the case of Lisa, at session 6, she states: "I feel stronger, that I want to get down into it more, like I want to fight it more". This is clearly in contradiction with the problematic self-narrative (more on this below) that has been organizing Lisa's way of feeling, thinking and acting; thus representing a unique outcome.

Thus, unique outcomes, or as we prefer *innovative moments* (IMs; also previously designated as i-moments), can be defined as all occurrences (thought, acted, imagined) that are different from the problematic self-narrative and are, in this sense, a representation of client self-change. They are openings to the elaboration of new meanings, challenging the hegemonic role of problematic self-narratives in clients' lives. As problematic self-narratives impose severe constraints to meaning construction in clients' lives, IMs are all the times these constraints are broken by the client. Thus, if the problematic self-narrative is the rule (of behaving, feeling, thinking, and relating) dominant at a given time in client's lives, IMs are all the exceptions, no matter how incipient and poorly elaborated they are. To track IMs, the researcher needs, in fact, to

clearly have in mind what the problematic story is (the rule) in order to identify what will constitute a narrative innovation or change (the exception).

The Innovative Moment Coding System (IMCS) identifies five different types of IMs:

1. *Action* IMs refer to specific new actions that are intentionally engaged in by the client and are different than one would expect, keeping in mind the constraints the problematic self-narrative imposes on the client's actions.

2. *Reflection* IMs are those events in which the client understands something new that directly contradicts or challenges the problematic self-narrative.

3. *Protest* IMs are actions (like action IMs) or thoughts (like reflection IMs) that express a direct refusal of the problematic self-narrative and its assumptions. These IMs are present when the client begins to voice some sort of dissatisfaction with the limiting consequences of the problematic self-narrative. Protest involves a different way of repositioning the self in relation to self and others and results in more proactive, agentic stance in therapy. For instance, reflection IMs can emerge as a new understanding (e.g., "I discovered that I have this tendency to criticize myself all the time, like my mother used to do to me"), whereas protest IMs can appear as a way of more proactively refusing the assumptions of the problematic self-narrative (e.g., "I won't accept anymore this critical view my mother had of me!").

4. *Re-conceptualization* IMs represent a complex form of meta-reflective meaning construction that indicates that the person not only understands what is different about him or herself, but can also describe the process that was involved in this transformation. These IMs involve three components: the self in the past (problematic self-narrative), the self in the present, and the description of the processes that allowed the transformation from the past to the present. Hence, these IMs involve a meta-

position regarding the change process, given the access the person has to the ongoing change. We think that this access, absent in the other IMs, is fundamental in psychotherapeutic change, given the fact that it positions the person as an author of the change process. This is congruent with the claims done by several authors (e.g., Dimaggio, Salvatore, Azzara, & Catania, 2003; Hermans, 2003) suggesting that change occurs in psychotherapy because there is a new subject position that emerges, which provides a new perspective from which other positions of the self can be articulated. These researchers emphasize the development of meta-cognitive skills in the development of therapeutic change (see also Semerari, Carcione, Dimaggio, Nicolo, Procacci et. al., 2003). This meta-position is akin to what we refer to as an authoring position, allowing the person to reorganize the several positions in his or her repertoire. In fact, re-conceptualization IMs need meta-cognitive skills to be present.

Also, the three elements necessary for re-conceptualization to appear (past position, present position, and identifying the processes that allow the transformation from the first to the second condition) imply necessarily a narrative structure connecting past with the present, which seems to be absent in other more fragmentary IM subtypes. As such, re-conceptualization IMs are essential for the establishment of a new, coherent self-narrative that gives meaning to the range of IMs types identified and elaborated in earlier sessions.

5. *Performing change* IMs entail new projects, activities, or experiences that were impossible before, given the constraints of the problematic self-narrative. They represent a performance of the change process and may function as a projection of a new intentions, purposes, and goals that shape the emergence of a new self-narrative. These IMs represent the expansion of the emerging new self-narrative into the future.

Further descriptions and exemplifications of the different types of IMs are provided in the coding manual (Gonçalves, Ribeiro, et al., 2010) and in previous published papers (Gonçalves et al., 2009; Matos et al., 2009). Examples will also be reported next in the analysis of this case.

From the analysis of case-studies and the intensive research done with small samples (see Matos, Santos, Gonçalves, & Martins, 2009; Santos, Gonçalves, Matos, & Salvatore, 2009; Santos, Gonçalves, & Matos, 2010) we have constructed a heuristic model of change. According to it (see Figure I - 1) change starts with action and reflection IMs, as the most elementary kind of novelty in which the client starts wondering about how life could be if it were different (reflection IMs) and performing new actions (action IMs) congruent with these reflection IMs (or the other way around, from action to reflection). Several cycles of action and reflection (or, inversely, from reflection to action) may be needed to ensure that, to the client and to others, something really different from the problematic self-narrative is happening.

Sometimes protest IMs also emerge from the beginning, as a form of protesting life from the problem, and in this movement creating a very proactive and powerful position ("I really want to change, I won't stand life like this anymore!"), whereas other times protest IMs only appear after some development of reflection and action IMs.

Usually at the middle of the therapeutic process, re-conceptualization emerges, positioning the client as an author of the change process (given the access to the process of change), articulating the past condition and the present one, integrating the diversity of IMs that emerged until the moment, in this way facilitating the creation of a new narrative of the self, able to compete with the former problematic self-narrative. Performing change IMs are projections into the future of this new position. Our model also suggests that this process could develop through cycles of action, reflection,

protest, followed by re-conceptualization, stimulating new action, reflection, and protest IMs, stimulating again new forms of re-conceptualization, and so on, until a new narrative of the self clearly emerges. We hypothesize that this occurs by the accumulation of IMs and also by the pattern of this accumulation (first action, reflection and protest; then re-conceptualization and latter performing change), leading a new self-narrative to compete with the problematic self-narrative in the organization of the client's daily experience.

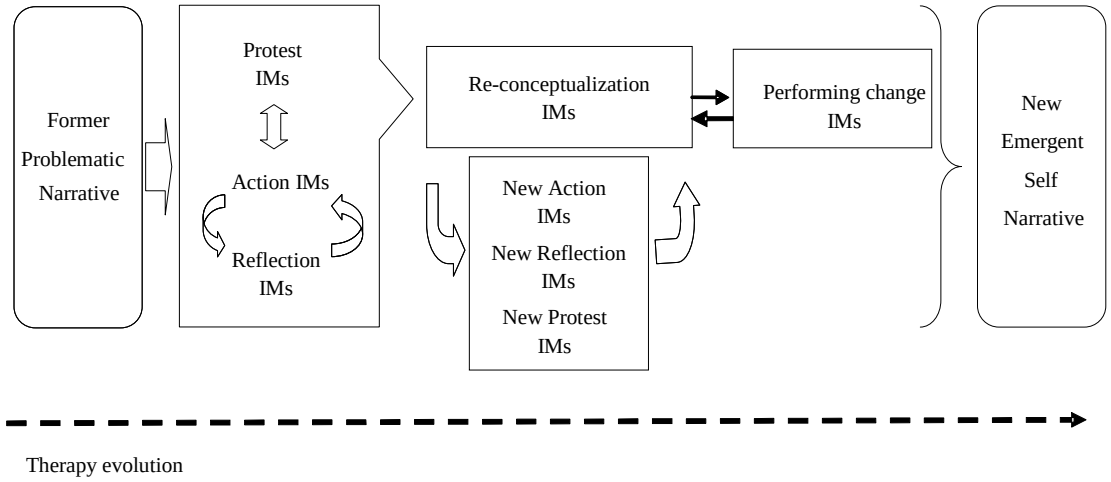

Figure I – 1. IMs and the creation of a new narrative.

In our ongoing research program at the University of Minho (Portugal), we have become interested in exploring if the IMCS can be applied to different psychotherapeutic models, outside the narrative tradition. It is our hypothesis that, independently of specific therapeutic models and their specific techniques, effective therapists aim to reduce the power of clients' problematic self-narratives, helping them to construct new understandings of old problematic stories as well as undertake new

actions, thus creating IMs (see Dimaggio, 2006; on the different meanings of problematic self-narratives).

This is the first case study analysis to apply the IMCS to a psychotherapy approach not influenced by narrative therapy and as such will be informative in a number of different ways. First, it will demonstrate whether the coding system can be applied to emotion-focused therapy. Second, it may be informative about the nature of narrative change processes occurring in an emotion-focused therapy of depression. Finally, it may be relevant to clinicians who use EFT, helping them stimulate and sustain narrative change.

3. THE PRESENT STUDY

In this contribution, our goal is to study the process of narrative change in EFT with one good outcome case of a patient with depression. All therapy sessions were coded using the IMCS in order to track the types of IMs that occurred within and across sessions. In contrast to narrative therapy, where therapists intentionally search for client generated IMs and pose questions to elaborate their meanings, EFT therapists are more concerned with accessing, identifying, and restructuring problematic emotion schemes (Greenberg & Watson, 2006). Therefore, the aim of this study is to investigate the occurrence of IMs and narrative change in one EFT case and to assess whether the application of the IMCS can facilitate a richer theoretical understanding of how client change occurs in EFT of depression.

4. METHOD

4.1. Client

Lisa was a 27-year-old woman who was married and had two school-aged children at the time of her participation in the York I Depression Study (Greenberg & Watson, 1998). She described herself as coming from a working class background, and was not employed at the beginning of treatment. She had secured part-time employment, however, before treatment termination. Lisa met criteria for inclusion in the York I Depression Study on the basis of her diagnosis of Major Depressive Disorder (MDD), assessed using the Structural Clinical Interview for DSM-III-R (SCID; Spitzer, Williams, Gibbons, & First, 1989). Lisa was randomly assigned to EFT and was seen for 15 sessions.

Lisa reported feelings of sadness, guilt, and resentment towards her family and was unable to articulate the root of her depressed feelings prior to entering therapy.

The case of Lisa was selected for intensive process-outcome analyses on the basis of significant symptomatic change evidenced on pre-post standardized assessment measures. Her pre therapy BDI score of 23 dropped to 3 at therapy termination and 0 at three month follow-up. A Reliable Change Index (RCI) analysis of her BDI pre- to post-test change scores classified Lisa as having met criteria for recovered (i.e., passed both a BDI cut-off score of 11.08 and RCI criteria) at treatment termination (see Jacobson & Truax, 1991; McGlinchey, Atkins, & Jacobson, 2002). All 15 therapy sessions were transcribed as part of larger process-outcome study of client-centered and EFT treatments (Greenberg & Angus, 1994).

4.2. Therapist

Lisa's therapist was a female doctoral student in clinical psychology with two years of prior clinical experience as a psychotherapist who had undergone a 30 hour training program in EFT prior to participation in the study.

4.3. Researcher

The researcher working with the case of Lisa was a woman in her middle twenties doing her PhD dissertation, integrated in a team of researchers studying the change processes using the IMCS. Another PhD student, trained in this coding system also participated in the case-study by independently coding 50% of the sample (see below).

4.4. Measures

To study the process of change, the case was coded using the IMCS' Manual (Gonçalves et al., 2009; Gonçalves, Ribeiro, et al., 2010). We will give examples below (see Results section) of the different IMs in the present case. Table I - 1 describes how the IMs were identified and gives examples of the diversity in each type.

Table I – 1. Types of IMs and examples. From Innovative Moments Coding System (Gonçalves, Ribeiro, et al., 2010). Adapted with permission.

Types of IMs	Examples
Action IM Actions or specific behaviors against the problem.	New coping behaviors facing obstacles; Effective resolution of unsolved problems; Active exploration of solutions; Restoring autonomy and self-control;

	Searching for information about the problem.
Reflection IM Thinking processes that indicate the understanding of something new that makes the problem unacceptable (e.g., thoughts, intentions, interrogations, doubts).	New problem formulations and/or awareness of its effects; Reconsidering problems' causes; Considering cognitive and affective dilemmas; Reflecting about cultural, social and religious demands supporting the problem; References of self worth; Feelings of well-being; Adaptative self instructions and thoughts; Reflecting about the intention to fight problems demands.
Protest IM Attitudinal defiance of the problematic self-narrative, that involve some kind of confrontation (directed at others or versions of oneself); it could be planned or actual behaviors, thoughts, or/and feelings.	Cognitive, behavioral and emotional defiance towards constraints; Assertive attitudes towards others; Repositioning towards cultural, social, religious demands supporting the problem.
Re-conceptualization IM Process description, at a meta-cognitive level (the client not only manifests	References to new/emergent identity versions; Re-evaluation of relationships;

thoughts and behaviors outside of the problematic narrative, but also understands the processes that are involved in it).	Reframing of previous problems; Redefinition of versions of others.
Performing change IM References to new aims, experiences, activities or projects, anticipated or in action, as consequence of change.	Generalization into the future and other life dimensions of good outcomes; Problematic experience as a resource to new situations; Investment in new projects as a result of the process of change; Investment in new relationships as a result of the process of change.

4.5. Procedures

For the present study, the raters, after a careful reading of the entire psychotherapeutic transcripts, defined consensually what the problematic self-narrative was in this case. Table I - 2 presents the different aspects of the problematic self-narrative that were tracked with the IMCS in the 15 sessions of therapy. The definition of the problems was linked to the verbal material, that is, close to client's discourse, allowing the identification of the IMs in relation to it. Based on the transcripts of the sessions, raters identified the following problem's main *rule*: accept, please, and help others around her, namely her husband and parents (see Table I - 2 for further description). This definition of the problem is supported by other case-studies done with this case (see, for instance, Angus, Goldman, & Mergenthaler, 2008; Brinegar, Salvi, & Stiles, 2008). Accordingly, every time Lisa considered the consequences and the effects

that this way of acting had on her life and every time she repositioned herself against the others' expectations, focusing on her own feelings and needs was considered an IM. In addition, Lisa reported feelings of sadness, guilt, and resentment. Hence, raters also coded every expression of reduction of those feelings and moments of well-being as IMs.

Table I - 2. Lisa's problematic self-narrative and IMs.

	Problematic self-narrative	**Examples of IMs**
Sadness	L: Yeah, [I feel] neglected or rejected or um, just there for the purpose of being there as the provider for the kids and … T: Mm-hm. So kind of just left all alone holding the bag. L: Yeah, I guess … I hold a lot on my shoulders.	L: I feel content because, um, I do have friends now. L: Yeah, I feel pretty satisfied at this point.
Guilt	L: Yeah, when I, if I do go out to the store and you know, I may take, whatever, a couple of hours (laugh), an hour and hour and a half, um, sometimes I feel guilty about doing that. C: (talking to her husband in empty chair task) - - - um, there's a lot of making me feel like I'm a bad person. And I've just got to keep on trying, just, no matter what happens; just accept you the way you are and just shut-up.	L: Let me explore, mm-hm, let me grow and explore, and just let me find myself. L: Um, I don't want to live like that, I want to be able to enjoy life, to let out my creativity and I want to blossom… I deserve that.

Resentment and difficulty in expressing her own feelings	L: … maybe that's why I don't tell him (husband) how I really feel inside (sniff) … Yeah, there's, or um, even though I express it, it's just kind of laughed at. L: For me to express this, yeah, it's a little, it's sad and it's scary. T: Uh-huh. What were the rules (in your family)? L: Uh, to respect, be nice to everybody, don't talk back... L: Yes, scared (crying). Scared - - I feel that I always had to be a good girl in front of him... and, if I'm not, then I'm no good.	L: …but then my feelings are my feelings and (sigh) and I'm entitled to them. L: I don't want to um, resent my mother ... because then I find when I do that I stay stuck. L: Yeah, just accept me the way I am…..
Lack of assertiveness	L: He'll (husband) raise his voice and I simmer down and either walk away, or just forget about what was said and I don't fight it out. L: Um, yeah, or just better shut up and that's it. I've never tried to go over my limit (laugh)	L: Yeah that's what I say to myself, why don't I, you know, why, excuse me, why don't I stand up for myself. L: I'm not responsible for his actions (husband). L: I am me and these feelings belong to me, and if I want to tell you I will.

After this consensual decision, the raters then identified individual thought units (Hill & Lambert, 2004) according to content shifts in the dialogue, in each therapy session transcript. A thought unit was identified when a shift in therapeutic conversation occurred, when either therapist or client started to talk about something new. From our perspective, the process of change is co-constructed between the client and therapist so the unit of analysis may contain both client and therapist turn taking (Angus, Levitt, & Hardtke, 1999). Therefore, the IMs could result from questions or tasks suggested by the therapist, but they were only coded as IMs if the client elaborated on them. For instance, if the therapist posed a question that contained an IM and the client denied it or did not elaborate on it in some way, it was not coded.

Once identified, each thought unit was then coded independently in terms of the presence of one of five IM types (e.g., action, reflection). The five categories were mutually exclusive. All the sessions were coded in a sequential order (session 1, 2 ... until the last one). We preferred to use salience as a measure of the IMs, which was the amount of time that clients and therapists spent elaborating a given IM, instead of frequency, since the former is a more direct indicator of narrative elaboration. Frequency is simply the appearance of one IM, giving no information about how long therapists and clients were elaborating the theme. Salience is measured by counting the time with a chronometer of each IM (temporal salience index), or when we use transcripts (as happened in this case) by counting the proportion of the words involved in each IM (textual salience index).

The coding system involved a three step process, involving identification of: (1) whether an IM was present or absent for every thought unit of the therapeutic process, (2) if present, what type it was, and finally (3) the beginning and the end of that IM had

to be rated, so a measure of its salience could be obtained. For each session, we computed an index of salience for each of the five IMs, as the percentage of text in the session occupied by that type of IM (e.g., reflection, protest). This percentage was computed by calculating the amount of words involved in each type of IM, for each session, and dividing by the total amount of words in the transcript of the session. We also computed an index of overall salience of each IM for the entire therapy, which is the salience mean of a given type of IM across all sessions.

4.6. Reliability

During the training period with the authors of the manual, raters had weekly meetings with all members of the research team who were also being trained. Between meetings, they coded psychotherapy transcripts. In our research team, all members were studying the process of change with the IMCS, collecting data from different psychotherapeutic approaches (e.g. Narrative Therapy, Emotion Focused Therapy, Cognitive-Behavioral Therapy) and also the process of change in everyday life. The process of training included reviewing the manual with the authors, coding transcripts from the data collected by each member of the research team, discussing disagreements and misunderstandings in the process of coding until a consensus among every member was established. At the end of the training period, an interrater reliability of these two raters was based on their ratings of the IMs in a set of selected excerpts of dialogues of therapeutic sessions and interviews (Cohen's Kappa was .82 and .83). After this training process, the raters started coding cases from the EFT samples (Greenberg & Watson, 1998; Greenberg & Angus, 1994).

The inter-judge percentage of agreement for salience was 84%. This means that there was an overlapping of the thought units between both raters in 84% of the

transcripts of the 15 sessions. Thus, for example, one rater could have rated reflection IM, while the other could have coded protest IM but they agreed that this thought unit is an IM. This measure of agreement means that both raters agree that a given thought unit is (or is not) an IM in 84% of the text. As a measure of the agreement regarding the specific type of IM, we used Cohen's Kappa, which in this case was .76, showing a strong agreement between judges (Fleiss, 1981, quoted by Hill & Lambert, 2004).

5. RESULTS

In the analysis of this case we followed the suggestion made by Stiles (2007) for a "theory-building case study". In light of this framework "each case analysed using a theory has the potential to support, disconfirm, elaborate, or in some way modify statements in the theory" (Brinegar, et al., 2008, p. 8). Along these lines, theory should be changed by new observations while still making sense of the past ones (Brinegar et al., 2008). Thus, we will present the therapeutic change processes according to the IMCS in this section, and the unique insights and challenges that this good outcome case poses to our change model will be the target of the discussion section.

5.1. Overall Findings

The analysis revealed that IMs were 35% of all the 15 sessions (overall salience) meaning that this percentage of the text that comprised the entire therapeutic transcripts contained therapeutic conversations that were different from the problematic self-narrative, or in other words, it was constituted of innovations. Of course, as we will discuss below, this number is not constant across sessions, and some sessions have much more time devoted to IMs, whereas others have much less (the first session is the one with lowest salience – 19%, and session 8 is the one with the highest salience – 50%).We emphasize that this percentage reflects all the moments in which the

problematic self-narrative was somehow defied, be it in a more elaborated and definitive form, or more incipiently and tentatively.

The type of IM that presented highest salience in this case was protest (14.95%) and the second one was reflection (11.20%). Re-conceptualization occupied 7.06% of the entire therapy, and the percentage of action (0.52%) and performing change (1.10%) was negligible (see Figure I - 2).

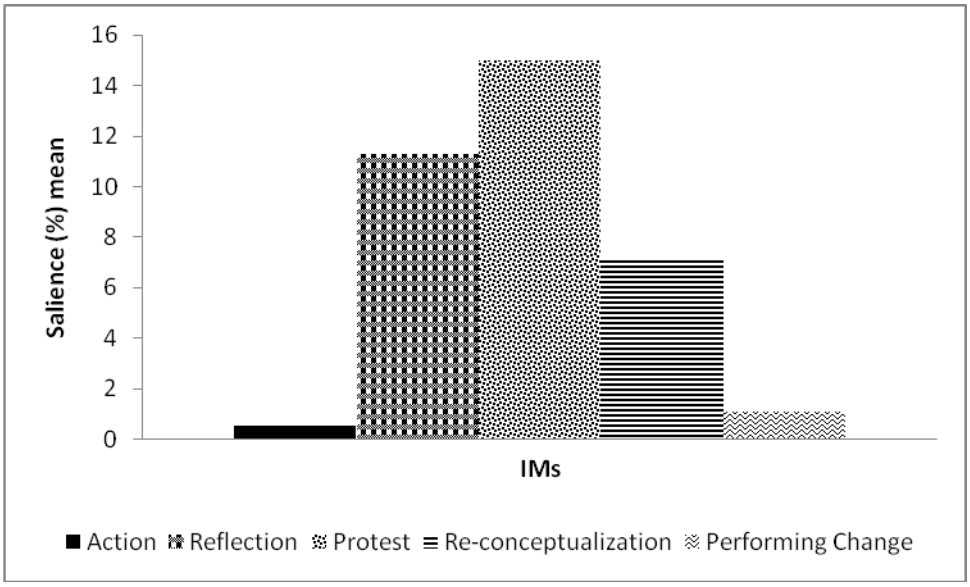

Figure I – 2. Overall salience of IM types.

5.2. Occurrence of IMs Types across Therapy Sessions

In what follows, we analyze the way the different types of IMs evolved throughout the therapeutic process. Figure I - 3 depicts the evolution of reflection, protest, and re-conceptualization IMs. Action and performing change IMs are not represented given their very low salience.

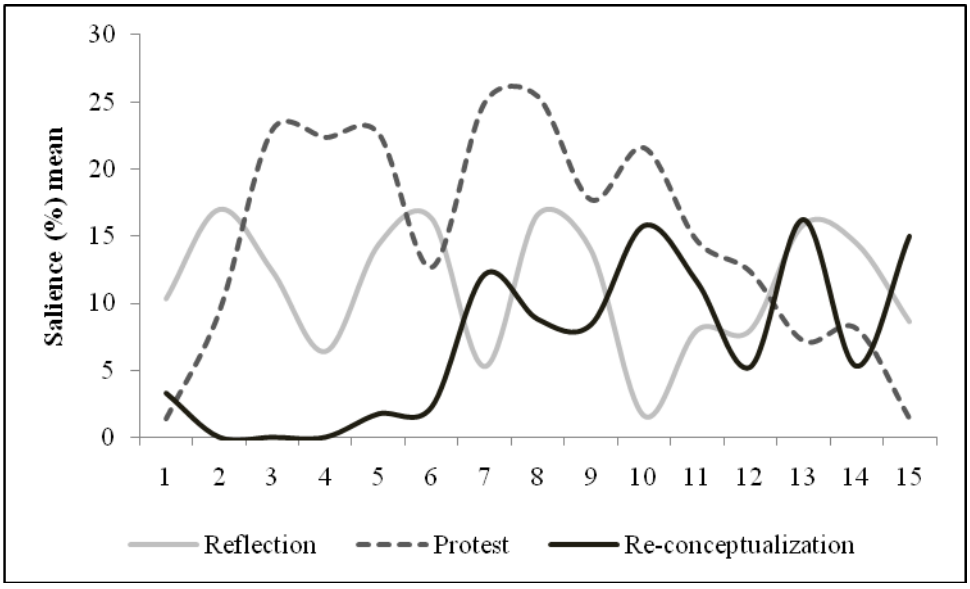

Figure I – 3. Salience of IMs of Reflection, Protest and Re-conceptualization throughout the therapeutic process.

5.2.1. Action IMs. Action IMs were the ones that presented the lowest salience of all IM types identified in this case. This type appeared in only six sessions and achieved a low salience score in most of those sessions. The only exception occurred in session 6, when Lisa described a situation in which she had been arguing with her husband, and then decided to end it by going to church. Even though the disclosure of this story only occupied 4% of session 6, the elaboration of this action IM was the example with the highest salience of this type in the therapy as a whole. Despite the low salience, this event was very important to Lisa because it represented a withdrawal from the husband and what he represented in Lisa's life, and an investment in God and in the support the church offered.

This low salience of action IMs in this case illustrated that what changed most for Lisa were the meanings that she attributed to her marriage and to her family, mainly her role as a wife and as daughter. The great majority of innovations were situated in the realm of meaning, in the form of reflection, protest, or re-conceptualization IMs.

5.2.2. Reflection IMs. Reflection IMs had an interesting pattern of "ups and downs", but were consistently present across sessions (11.20 %).

Salience of reflection IMs increased in sessions 2, 6, 8 and 13 and decreased in sessions 4, 7, 10 and 15. This suggests the presence of cycles wherein Lisa engaged in more in-depth elaboration in the reflection mode, followed by low elaboration. Notably, with the exception of the last session, the decreases (session 4, 7 and 10) clearly coincided with an increasing engagement in protest IMs, as if the involvement of therapeutic dyad in tracking reflection IMs was substituted at those sessions by protest novelties. Since the middle of therapy, the sessions in which reflection IMs decreased (7, 10 and 15) also coincide with an increase in re-conceptualization IMs, which suggests that Lisa was engaged in a more elaborated type of innovation. The content of reflection IMs revealed diverse features: new understanding of key problems, identifying strategies used to change the problem, identifying strategies that she can use in the future, and feelings of well-being that resulted from these changes. In the beginning of the therapy, the majority of reflection IMs mainly involved new formulations about the problem and new understanding of their causes, as is illustrated in the following empty chair dialogue with her father in session 3:

Lisa: Yes, scared (crying), scared - - I feel that I always had to be a good girl in front of him… but then again it feels like a phony act.

Therapist: uh-huh. Can you tell him that "I don't want to be phony."

Lisa: I don't, it um, makes me feel really uncomfortable.

From these new understandings, Lisa started to reject taking responsibility for what she now understood as others' problems and this allowed her to assume a new subject position that enabled a new perspective on herself to emerge. In the following example, from session 8, Lisa elaborated about what she was feeling after an empty

chair dialogue with her husband, in which she expressed her disappointment about her marriage and decided that she was not going to support him anymore.

Lisa: Relief, um, I've done what I can I – it it just isn´t working, I'm bouncing my head against the wall [waiting for the husband to change and supporting him].

Therapist: And you just can't go anywhere else

Lisa: No, I can't go anywhere else, that's why I've turned to, to God and, and the, the support of the Church because *I just don't want to harm myself I don't want to hurt myself anymore*. [Signaling a new position that will help her to focus and reclaim her needs].

As evidenced in session 12, reflection IMs continued to focus on the strategies to deal with problems during the final phase of the therapeutic process (after session 10), allowing Lisa and her therapist to differentiate new self-positions as in session 12.

Lisa: (crying) I want to um grow and um, experience what I have to offer and um, um, just to learn about what's out there.

Therapist: Mm-hm. What's happening when you say that?

Lisa: yeah, I'm positive about it.

...

Lisa: I feel positive and strong.

Therapist: Mm-hm.

Lisa: *It's okay to ask for these things* [acceptance of who she is and what she feels].

Therapist: You feel okay about it?

Lisa: Yeah, yeah, it's a- it's a part of me, so I'm not going to um, turn it down.

5.2.3. Protest IMs. The salience of protest IMs increased significantly until the middle phase of the therapy (session 8) and then had a considerable decrease (it has a shape of an inverted U). Protest IMs mainly emerged from experiential tasks, like the

two chairs dialogue (between the experiencing self and the critical self) and in the empty chair dialogue (with her mother, father and husband).

In the beginning of therapy, protest IMs primarily took the form of confrontation and critique of the problem. The client simply positioned herself against the problem, without any elaboration about what change would be like, or what new meanings could emerge from the confrontation of the problem. In the following empty-chair dialogue with her father from session 3, Lisa is expressing her anger about the way she was brought up, with the sense that she had no right to express her feelings and that she had to do what her parents expected from her and what makes them happy.

Therapist: Okay, so tell him about the anger.

Lisa: Um, why didn't you (her father), um ever do anything about it? - - Um, you're a responsible adult and it's your own problem.

Therapist: Alright, tell him that, it's real important. "You're responsible, I hold you responsible for your actions, you're an adult."

Lisa: You're responsible for your own - actions, you're, you're an adult. Why did, me and mom and the rest of my brothers have to um (sniff), um, be affected by it (gambling)?

Therapist: mm-hm. Tell him how you were affected by it.

Lisa: Um… to, um, not to bring up how we felt about it, uh, it was to be kept as a secret.

Therapist: Uh-huh. "I had to push everything down, I had to pretend it wasn't happening," right?

Lisa: Yeah, not, not to be real.

Therapist: Can you tell him, "I resented having to pretend?"

Lisa: Yeah, I, I resented to pretend living that way, I, it really makes me angry.

Therapist: Tell him that anger really makes you angry.

Lisa: Um, it wasn't fair to be brought up that way. I think you're very selfish!

Therapist: Say that again.

Lisa: I think you're very selfish!

This critical position decreased throughout the therapeutic process. Lisa started expressing her feelings, poorly acknowledged before, and from here a new position of assertiveness and empowerment developed. This position allowed her to express her needs and rights, putting herself in a position of entitlement, actively refusing the assumptions of her problematic self-narrative and the people who supported them. This kind of protest was rather different from the first one described before. Here, new dimensions of meaning emerged, in addition to a critique of the problematic self-narrative. The confrontation of the problem was associated with new dimensions of meaning, mainly in the form of asserting preferences and options. In an empty-chair dialogue with her husband in session 5, she stated:

Therapist: Mm-hm. So what do you feel towards him right now?

Lisa: Umm... I feel bigger – um, taller.

Therapist: - Mm-hm. Tell him, "I feel…."

Lisa: I feel bigger and, and taller and… I feel that I can… stand up for myself -

Therapist: Mm-hm. What happens when you say that? "I feel I can stand up for myself." You can just… get up and walk out. Tell [him].

Lisa: Because, um -I'm an adult and… I can make my own decisions… and I'm not going to take… and put up with what you say to me, because I don't deserve to hear that, or be treated that way.

Therapist: What do you deserve?

Lisa: Um - - I deserve to feel what I feel and, and, ah… do what I want to do that

is right for me and my kids. I'm going to stand up for myself. Um - I deserve that. I'm a good person and I'm not going to let you step on me anymore.

This evolution from protest centered on the critique of the problem to protest that emphasizes the needs of the self created a new self-position, beyond the mere reaction to the problem.

5.2.4. Re-conceptualization IMs. Re-conceptualization IMs had a very low salience in session 1, were absent from sessions 2 to 4, re-emerged in session 5 again with a low salience, and increased over time after that. However, despite brief occurrences in sessions one and 5, re-conceptualization IMs did not start to have a significant salience until after session 6. A good example of a re-conceptualization occurred during session 15, in which Lisa narrated her transformation process, from a meta-reflective position.

Lisa: Yeah, yeah get back into my feelings, yeah and that's, I guess, because the awareness I know is there now, and before I never knew it existed (laugh). So I'm an individual, I realize I'm an individual, and I have the right to vent my feelings and what I think is right or good for me and that's been the improvement of the therapy. like that I think of me and myself.

Therapist: Yeah, really finding your feet.

Lisa: Mm hm, as an individual yeah, which before I-I thought I was glued to him (laugh). Yeah, I didn't have an existence and now I do, and that's a good feeling.

Lisa clearly contrasted her previous self and her present self, elaborating the process of change that facilitated this important shift. In the final phase of therapy, in re-conceptualization IMs, Lisa spent even more time elaborating on the changes that she was able to make during the therapeutic process, assuming the authoring of change and the construction of a new narrative of the self.

5.2.5. Performing change IMs. It was only during the final session of therapy that Lisa articulated performing change IMs in a substantial way that represented new ways of dealing with her marriage and the relationship with her parents. These IMs were a performance of the change process that represented the new views of the self that were articulated in the context of re-conceptualization IMs. In this session, Lisa and her therapist spent 11% of their time elaborating this type of IM.

Lisa: I-I've been feeling okay, like actually getting out and seeing other people and being into the school.

Therapist: Yeah.

Lisa: Because that's what… I like doing that around the kids.

Therapist: Yeah.

Lisa: I think that's important .

Therapist: That's nice.

Lisa: Yeah it's been a, you know, it's like it, everything kind of follows through, it's like, I didn't expect what was going to happen throughout the year.

The reduced salience of performing change IMs reflects, in our view, the manner in which Lisa changed – more by the transformation of intrapersonal meanings than through engagement in new actions (present both in action IMs and performing changes IMs) and new interpersonal events.

6. DISCUSSION

As suggested by Stiles (2003, 2005), we will discuss the results taking into account to what extent the observations from the Lisa case converge with the theory and other case studies analyzed through the IMCS lens and also how they may invite us to refine the theory. The intensive case analysis of Lisa with the IMCS revealed some

interesting similarities and differences when compared to previous findings established in the context of good outcome narrative therapy cases (see Matos et al., 2009).

First of all, Lisa had almost two times the salience of IMs than the most successful case of narrative therapy we have studied. Of course, the cases from these two samples were not comparable, and this could be a mere effect of the kind of clients that were studied in the narrative therapy sample (women victims of intimate violence, see Matos et al., 2009). Another possibility is related to the systematic use of therapeutic tasks in EFT, which elicited, by using two-chairs and empty-chair procedures, a considerable number of IMs and could have had the effect of increasing their salience (given the time spent in these experiments). This difference needs to be addressed in future studies, by comparing the same kind of clients with different types of therapeutic approaches.

Besides this quantitative difference, there are several commonalities with the other good outcome cases studied (Matos et al., 2009; Ribeiro, Gonçalves, & Ribeiro, 2009). As in other good outcome cases, reflection and protest were clearly the most common types of IMs. We also found the typical pattern of emergence of re-conceptualization in the middle of therapy with an increasing tendency until the end. Lisa's therapeutic process was thus compatible with the tentative model presented at the introduction concerning the role of reflection, protest, and re-conceptualization IMs.

One main difference from this model of change was the near absence of performing change IMs. Perhaps this is a difference that resulted from the fact that the model presented in the introduction was constructed from the study of narrative therapy cases, in which therapists try to help clients extend their new self-narratives into the future. Narrative therapists give an important role to how the imagination of different futures shapes the present and has the potential to change the way the self-narrative is organized in the present (see White, 2007). Thus, perhaps the significance of

performing change in the model presented above reflects this importance given to the future.

In contrast, emotion-focused therapy (Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006) tries to center the client in the here and now of the present moment, and in this way a focus on projection or elaboration of new meanings for the future may play a more limited role in the treatment process. EFT focuses on the present moment and within-session enactments for the articulation of new emotional meanings and in so doing, places less emphasis on the client's narrative descriptions of actions in the world. With very few action IMs, and a strong component of novel meanings, first in the form of reflection and protest and then in the form of re-conceptualization, findings from the IMCS analysis of Lisa's therapy sessions provides some preliminary empirical support for this perspective. All these IMs centered on the meaning side of experience are congruent with the way Lisa changed: focusing on herself and on her needs and giving priority to her feelings instead of what she was supposed to feel. Also, Brinegar and colleagues (2008) emphasize that Lisa's change took place without any significant change in her current life (e.g., at the end of therapy she is still married to the same man, who keeps spending their money in gambling).

Another possible explanation is that, in this case, the majority of action IMs emerged in the form of protest. Protest IMs can occur in the form of actions or reflection and perhaps the use of empty and two chair dialogues increased action in the form of protest in the sessions. Even with this interpretation in mind, it is clear that in this case innovative actions outside therapy have a low salience in the therapeutic conversation.

At a process level, Lisa's case also allows us to clarify the role protest IMs could have in the process of change. In this case, protest IMs created a reevaluation of Lisa's

position toward the problems that bring her to therapy, creating a sense of agency. Protest IMs allowed her to create a distance from her husband and from her parents, expressing her feelings and needs and entitling her to assume that these emotions were meaningful and acceptable. This position constructed through protest IMs was validated by all the reflection IMs, perhaps creating a pattern of mutual reinforcement between these two types of IMs.

In this case, two very different kinds of protest IMs were elaborated, mainly in the context of chair work or as a consequence of these enactments (62% of protest IMs emerged during chair dialogues while only 26% of reflection IMs merged during these tasks). First, there was the emergence of a *problem-oriented position* consisting of a mere refusal of the problem. The first form of protest was still centered on the problem, in which the client spent her time criticizing the problem and the significant others who in her perspective were part of the problem. This form of protest can be very important at the beginning, but if it does not evolve to the second type of protest (see below) it can keep the person in a oppositional attitude towards the problem (e.g., criticizing her husband in Lisa's case) without innovating anything outside the theme of the problematic self-narrative (e.g., assuming her right to feel what she is feeling).

Subsequently a new type of protest emerged. This form of protest IM that heralds the *emergence of new ways of viewing and understanding the self* is clearly associated with a sense of empowerment, by emphasizing self's needs. This second form of protest IM brings new ways of understanding key concerns and conflicts, orienting the person to new ways of seeing and understanding herself. This type of protest IMs creates a very proactive, empowered position of the self (e.g., "I'm entitled to this").

Interestingly, this process is very similar to what Brinegar and colleagues (2008) also found with this case. They suggest that the voice of a resentful fighter (which is

similar to the first form of protest, centered on the problem) was integrated in the community of Lisa's voices giving rise to a voice of an empathic supporter of the self (similar to the second form of protest, centered on the self).

We hypothesize that the transformation involved in protest IMs, from protest centered on the problem to protest centered on the needs of the self, facilitated the emergence and consolidation of new, more empowered views of self to emerge in the context of re-conceptualization IMs, thus consolidating the change process. This is consistent with the analysis of Nicoló and colleagues' (2008) of this case. They reported that Lisa's initial state of mind was depressed and powerless, but towards the end the feeling of powerlessness disappeared and this was associated with positive self-efficacy. Congruent with this change, Lisa's re-conceptualization IMs involved the emergence of new facets of the self, which may be an outcome of the increased engagement in empty chair and two chair role plays that fostered a heightened sense of self-empowerment and self-assertion, i.e. protest IMs. Thus, new self-positions that emerge with protest IMs may serve as scaffolding for the development of new views of self, present in re-conceptualization IMs. Indeed, towards the end of therapy, the decrease of protest IMs coincides with the increase of re-conceptualization IMs.

In this sense, we think that in Lisa's case protest IMs, given that they appeared most of the time in two chair and empty-chair dialogues, had the role of facilitating the affective and cognitive processing of her emotional experience that Greenberg and collaborators (Greenberg, Auszra, & Herrmann, 2007) associate with the therapeutic success, leading her to construct re-conceptualization IMs. If re-conceptualization is central in the change process, as we believe it is, perhaps in emotion-focused therapy one main route to re-conceptualization is through protest IMs.

7. LIMITATIONS

One main limitation of this case is the knowledge that the researchers had about the status of the case, namely, that it was successful. In other research projects, we were able to keep the main researcher uninformed about the status of the cases, but this was not possible in this case study. It is obvious that this awareness could have influenced the coding process of the case, although its good reliability reduces the dimension of the problem.

Another limitation is that we cannot be completely sure about the role of IMs in change process: they could be intermediate outcome measures or process measures. According to narrative therapy, they are process measures in the sense that their elaboration facilitates the change process, and as such a causal role is attributed to them. However, this claim has not yet been empirically studied, as far as we know.

8. IMPLICATIONS FOR RESEARCH

In the future, we will study whether this pattern of development of protest IMs appears in other cases and also in different therapeutic models, or if this pattern is specific to this case or to emotion-focused therapy, and the experiential tasks it poses for the client. We also wonder about the pattern of protest throughout the therapeutic process in a poor outcome case of emotion-focused therapy. We foresee that, in that case, the elaboration of protest IMs would be more focused on the problem (i.e., criticism/confrontation), and that it would not expand to the emergence of new positions (empowerment/assertiveness). This would validate our hypothesis that the pattern of protest IM that develops from a position of criticism to an empowered one is a promoter of change, leading to re-conceptualization IMs.

This case also corroborated our hypothesis that the IMCS allows the study of

change in therapeutic approaches outside the narrative tradition, in which the concept of narrative exceptions or IMs is not a central one in guiding the therapist.

Finally, we hypothesize that other models of therapy could emphasize other ways to achieve re-conceptualization (e.g., reflection, action). Until now, the most robust result that we have found is the centrality of re-conceptualization IMs in good outcome cases (Matos et al., 2009). We hypothesize from those results that therapeutic change is not possible without some form of re-conceptualization, although we have found that this can be achieved by different routes. In this case, the central way to achieve it was through reflection and protest IMs. One interesting question is whether different therapeutic models emphasize different routes to re-conceptualization and whether different clients, working in the same model, arrive at re-conceptualization through different routes.

9. IMPLICATIONS FOR PRACTICE

It is obviously very risky to make inferences for practice from one single case, and we need to further develop studies to make sure these results replicate in other samples and other case studies. If they replicate regarding performing change IMs in EFT, we would suggest that emotion-focused therapists should pay more attention to projection in the future. Perhaps some attention from the therapist to these IMs would facilitate a more secure development of a new self-narrative in the future. Even if emotion-focused therapy promotes action in the form of protest IMs by using two-chair and empty-chair dialogues as we have suggested, we believe that it could be also important to search for IMs outside the therapeutic space, mainly in the format of action and performing change.

Our results also suggest that therapists should facilitate the movement from the first form of protest (critique and opposition) to the second (centered on the self), if they want their clients to achieve a position of re-conceptualization. Obviously, more research is needed to confirm the generalization of these findings.

10. REFERENCES

Angus, L., Goldman, R., & Mergenthaler, E. (2008). Introduction. One case, multiple measures: An intensive case-analytic approach to understand client change processes in evidence-based, emotion-focused therapy of depression. *Psychotherapy Research, 18*, 629-633.

Angus, L., Levitt H., & Hardtke, K. (1999). The narrative processes coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology, 55*, 1255 – 1270.

Angus, L., & McLeod, J. (Eds.) (2004). *The handbook of narrative psychotherapy: Practice, theory and research*. London: Sage.

Brinegar, M. G., Salvi, L. M. and Stiles, W. B. (2008). The case of Lisa and the assimilation model: The interrelatedness of problematic voices'. *Psychotherapy Research, 18*, 657-666.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

Dimaggio, G., Salvatore, G., Azzara, C., & Catania, D. (2003). Rewriting self-narratives: The therapeutic process. *Journal of Constructivist Psychology, 16*, 155–181.

Dimaggio, G. (2006) . Disorganized narratives in clinical practice. *Journal of Constructivist Psychology, 19*, 103-108.

Greenberg, L. S., & Angus, L. E. (1994) *How therapy works*. Social Sciences and Humanities

Standard Research Grant.

Greenberg, L. S., Auszra, L., & Herrmann, I. R. (2007). The relationship among emotional productivity, emotional arousal and outcome in experiential therapy of depression. *Psychotherapy Research, 17*, 482–493.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process*. New York: Guilford.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client–centred relationship conditions and process interventions. *Psychotherapy Research, 8*, 210–224.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-Focused Therapy for Depression*. Washington: American Psychological Association.

Gonçalves, M.M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, *22*, 1–23.

Gonçalves, M. M., Ribeiro, A., Matos, M., Santos, A., & Mendes, I. (2010). The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & A. Gennaro (Eds.), *YIS: Yearbook of Idiographic Science 2009 - Volume 2*. Rome: Firera Publishing Group.

Gonçalves, O. F., & Machado, P. P. P. (1999).Narrative in Psychotherapy: The Emerging Metaphor [Special issue]. *Journal of Clinical Psychology, 55*, 1175-1177.

Habermas, T., & Bluck, S. (2000). the life story schema. Motivation and Emotion, Vol 24, No. 2, p.121 - 147.

Hermans, H. J. M., & Hermans-Jansen, E. (1995). Self-narratives: The construction of meaning in psychotherapy. New York: Guilford.

Hermans, H. J. M. (2003). The construction and reconstruction of a dialogical self. *Journal of Constructivist Psychology, 16*, 89–130.

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert, (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change (5th Ed.)* (pp. 84 - 135). New York: Wiley.

Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, *59*, 12–19.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

McAdams, D. P. (2001a). *The person: An integrated introduction to personality psychology*. Orlando, Fl.: Harcourt.

McAdams, D. P. (2001b). The psychology of life stories. *Review of General Psychology*, *5*, 100-122.

McGlinchey, J.B., Atkins, D.C., & Jacobson, N.S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy*, *33*, 529–550.

Nicolò, G., Dimaggio, G., Procacci, M., Semerari, A., Carcione, A., & Pedone, R. (2008). How states of mind change in psychotherapy: An intensive case analysis of Lisa's case using the Grid of Problematic States. *Psychotherapy Research, 18,* 645-656.

Ribeiro, A.P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de mudança em psicoterapia: Estudo de um caso de sucesso de terapia constructivista [Narrative change processes in psychotherapy: A case-study of successful constructivist therapy]. *Psychologica, 50, 181-203.*

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 449-466.

Santos, A., Gonçalves, M. M., & Matos, M. (2010). Innovative moments and poor outcome in narrative therapy. Counselling Psychotherapy and Research. DOI: 10.1080/14733140903398153

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Semerari, A., Carcione, A., Dimaggio, G., Faclone,M., Nicolo, G., Procacci, M., et al. (2003). The evaluation of metacognitive function in psychotherapy: The metacognitive assessment scale and its applications. *Clinical Psychology and Psychotherapy, 10*, 238–261.

Spitzer, R., Williams, J., Gibbons, M., & First, M. (1989). *Structured clinical interview for DSM-III-R*. New York: American Psychiatric Press.

Stiles, W. B. (2003). When is a case study scientific research? *Psychotherapy Bulletin, 38*, 6-11.

Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler & R. F. Levant (Eds), Evidence-based practices in mental health: Debate and dialogue on the fundamental questions (pp. 57-64). Washington, DC: American Psychological Association.

Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research*, *7,* 122–127.

White, M. (2007). *Maps of narrative practice*. New York: Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

CHAPTER II

NARRATIVE CHANGE IN EMOTION-FOCUSED THERAPY: HOW IS CHANGE CONSTRUCTED THROUGH THE LENS OF THE INNOVATIVE MOMENTS CODING SYSTEM?

CHAPTER II

NARRATIVE CHANGE IN EMOTION-FOCUSED THERAPY: HOW IS CHANGE CONSTRUCTED THROUGH THE LENS OF THE INNOVATIVE MOMENTS CODING SYSTEM?[2]

1. ABSTRACT

Aim: To apply a narrative methodological tool for the study of the change process in Emotion-Focused Therapy (EFT), replicating a previous study done with Narrative Therapy (NT). **Method:** The *Innovative Moments Coding System* (IMCS) was applied to 3 good and 3 poor outcome cases in EFT for depression to track the *Innovative Moments* (*IMs*) in the therapeutic conversation which are exceptions to the problematic self-narrative. IMCS allows tracking 5 types of IMs events: *action*, *reflection*, *protest*, *re-conceptualization*, and *performing change*. **Results:** The analysis revealed significant differences between the good and poor outcome groups regarding re-conceptualization and performing change IMs, which replicates the findings from a previous study. **Conclusions:** Re-conceptualization and performing change IMs seem to be vital in the change process.

2. INTRODUCTION

Increasingly, the field of psychotherapy research has begun to address the fundamental question of how do clients construct their own process of change in effective therapy sessions. The present study aims to address this question by intensively analyzing events that facilitate the construction of new meanings, designated

[2] This work is in press in the journal *Psychotherapy Research*, in co-authorship with Inês Mendes, Antonio P. Ribeiro, Lynne E. Angus, Leslie S. Greenberg, Inês Sousa and Miguel M. Gonçalves.

as *Innovative Moments* (or IMs, also designated in previous publications as i-moment) (Gonçalves, Matos, & Santos, 2009; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Matos, Santos, Gonçalves, & Martins, 2009).

According to the narrative framework human beings give meaning to their life events through the narration of themselves, others and the world (see Angus & McLeod, 2004; McAdams, 1993; Sarbin, 1986; White & Epston, 1990). The notion of IMs was inspired in White and Epston's (1990) concept of *unique outcomes*, defined as exceptions towards a problematic self-narrative. Thus, IMs are all the events in therapy in which the client describes or narrates him or herself differently than one would expect from the perspective of the problematic self-narrative that brought him or her into therapy. These can emerge in different forms, as a thought, a plan, a feeling, an action; that falls outside the influence of the *rules* of the problematic self-narrative that organizes the client's life. If the problematic self-narrative is the rule (e.g. lack of assertiveness – "He'll (husband) raise his voice and I simmer down and either walk away, or just forget about what was said and I don't fight it out."), then IMs are all the exceptions to this rule; all those times that the client experiences and narrates something that, implicitly or explicitly, challenges or rejects the problematic self-narrative that has been shaping his or her life (e.g." I am me and these feelings belong to me, and if I want to tell him (husband) I will.").

Through the study of IMs we can track when the first signs of client therapeutic change are taking place and how they develop into a new narrative of the self emerging during the therapeutic process. This research studies how IMs develop in Emotion-Focused Therapy (EFT), replicating a previous research from Matos et al. (2009) that analyzed how IMs developed in Narrative Therapy (NT) with women who were victims of intimate violence. In NT the therapist deliberately tries to elicit IMs, so one central

question of the present research is if this concept could be used outside its context of origin and provides a picture of the narrative change in a therapy that is not focused on narrative constructs, more specifically on exceptions to the problem.

3. INNOVATIVE MOMENTS CODING SYSTEM

The *Innovative Moments Coding System* (IMCS) (Gonçalves, Ribeiro, et al., 2010) provides a systematic, reliable method for the identification of IMs. IMCS allows the identification of five different types of IMs – *action, reflection, protest, re-conceptualization* and *performing change* (see Table II - 1).

1. *Action* IMs are new accomplishments, specific actions that are different from what the problem impels the person to do.
2. *Reflection* IMs refer to new ways of thinking, feeling and new understandings about the implications of the problem in the clients' life that allow for the client to defy the demands of the problematic self-narrative.
3. *Protest* IMs entail new behaviors (like action IMs) and/or new thoughts (like reflection IMs) against the problem, representing a refusal of its assumptions. This active refusal is the key feature that allows distinguishing protest from action and reflection.
4. *Re-conceptualization* IMs are a more complex and multifaceted type of IM that enables the clients' comprehension about what is different about themselves and the process that fostered this transformation. These IMs require the clients' description of three components: the self in the past (problematic self-narrative), the self in present and the depiction of the process that allowed for this change.
5. *Performing Changes* IMs represent the performance of change, new ways of acting and being that emerge from the occurrence of the change process. They

represent a process of transforming in-therapy outcomes into extra-therapy changes.

Table II – 1. IMs with examples. From *The Innovative Moments Coding System: A coding procedure for tracking changes in psychotherapy*, by M. M. Gonçalves, A. P. Ribeiro et al., 2010. Adapted with permission.

	Contents	**Examples (Problematic narrative: depression)**
Action	• New coping behaviors facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control ; • Searching for information about the problem(s).	C: Yesterday, I went to the cinema for the first time in months!
Reflection	***Creating distance from the problem(s)*** • Comprehension – Reconsidering problem(s)' causes and/or awareness of its effects; • New problem(s) formulations; • Adaptive self instructions and thoughts; • Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being. ***Centered on the change*** • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies; implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	C: I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go… C: I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it.

Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s). ***Emergence of new positions*** • Positions of assertiveness and empowerment;	C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!? C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.
Re-conceptualization	RC always involve two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs… T: How did you have this idea of going to the museum? C: I called my dad and told him: we're going out today! T: This is new, isn't it? C: Yes, it's like I tell you… I sense that I'm different…
Performing Change	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource to new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	T: You seem to have so many projects for the future now! C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.

In a recent process-outcome study conducted by Matos et al. (2009), 10 women undergoing NT (White & Epston, 1990) and who had been victims of intimate violence, were analyzed with IMCS. The results indicated that IMs appeared in both good (N=5) and poor (N=5) outcome cases. However, NT clients in the good outcome group were found to spend significantly more time in the sessions elaborating IMs. These overall

differences were primarily due to differences in re-conceptualization and performing change IMs. No significant differences were found in action, reflection and protest IMs. From these results, and several intensive case-studies, using quantitative, qualitative and mixed designs (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Ribeiro, Gonçalves, & Ribeiro, 2009; Santos, Gonçalves, & Matos, 2010; Santos, Gonçalves, Matos, & Salvatore, 2009), it was hypothesized that re-conceptualization and performing change IMs may be necessary for the client self-narrative change to occur.

4. HEURISTIC MODEL OF THERAPEUTIC CHANGE

On the basis of findings emerging from the studies detailed above, a heuristic model of narrative change was developed (Gonçalves et. al, 2009; Matos et. al, 2009) which is summarized below.

In the first stage of therapy, action and reflection are usually the first IM types to occur (see Figure II - 1). Action and reflection IMs are considered the most elementary forms of innovation, constituting signs to the self (and significant others) that distinct ways of acting, thinking and feeling are emerging in the client's life. Protest IMs may emerge after several cycles of action and reflection IMs and they can also occur in early therapy sessions. Protest IMs may emerge as an action or as a thought but either way they represent a more empowered position of the self towards the problematic self-narrative, implying a strong attitudinal movement against the problem's dominance of the client's life. Although these three types of IMs represent important new ways of clients experiencing and understanding their problematic self-narrative, they appear to be insufficient for the development of a stable new self-narrative.

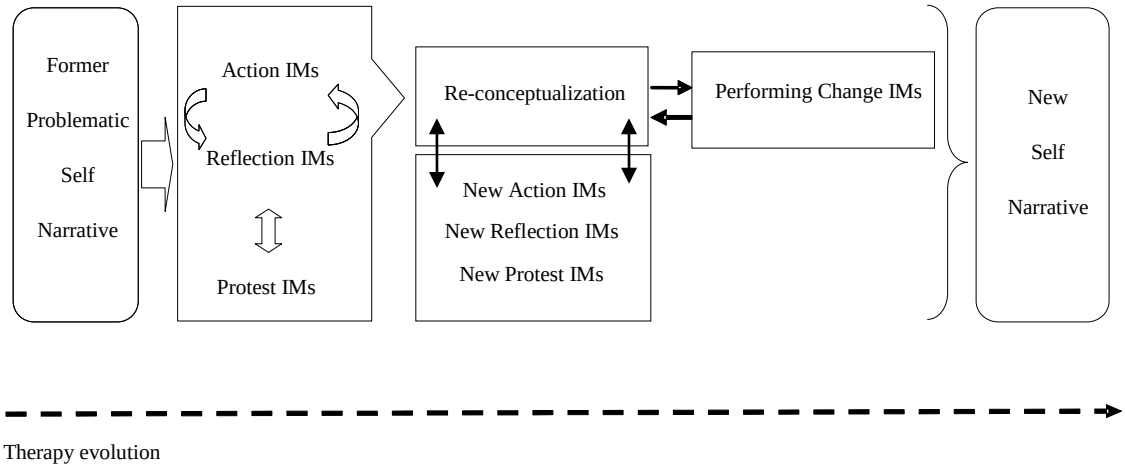

Figure II – 1. Innovative moments' heuristic model of change in psychotherapy drawn from Narrative Therapy.

In contrast, re-conceptualization IMs appear to be crucial for the construction of a new self-narrative as they represent the integration of the client's new view of self in the context of the problematic self-narrative. The emergence of this new vantage point on self, as the author of one's own self story, also involves a form of meta-reflection or meta-cognition (Dimaggio, 2006). We suggest that re-conceptualization IMs organize and give coherence to the diversity of action, reflection or protest IMs, heightening the narrative structure vital when forging a new story (see Baerger & McAdams, 1999). Thus, through re-conceptualization the client is not only able to integrate past with present and to assume an authoring position (given his or her access to the process of change), but can also give meaning and order to the more episodic innovations that emerge in the form of action, reflection and protest IMs. After the emergence of re-conceptualization new cycles of action, reflection and protest IM occur and validate the former re-conceptualization IMs. That is, as the client views him or herself different than before (re-conceptualization IMs) the further emergence of action, reflection and

protest IMs, that are congruent with this re-conceptualization, provide further validation that significant change is taking place. Performing change IMs are the portrayal of this new self in several domains of the clients' daily and future life, and they can entail the engagement in new projects, new relationships and new activities.

Finally, the model suggests that it is the articulation of this new gestalt of re-conceptualization IMs that allows for the emergence of a new self-narrative. In essence, a new set of rules guide actions, thoughts, feelings and ways of relate to others that are incoherent with the problematic self-narrative that brought the client to therapy in the first place.

5. PRESENT STUDY

The main goal of the present study is to investigate the emergence of IMs in EFT (Greenberg & Watson, 1998) using the IMCS (Gonçalves et al., 2009; Gonçalves, Ribeiro, et al., 2010). Since IMCS was inspired in NT (White & Epston, 1990) this study is also a test of IMCS' applicability to other therapeutic modalities. If applicable, then the study of the IMs with a different clinical population (major depression instead of women victims of intimate violence) and in the context of other therapeutic models, will raise new exploratory research questions:

1. Can the IMCS reliably identify IM types in EFT?
2. Do good outcome EFT cases present a higher proportion of IMs' than poor outcome cases; as occurred in NT?
3. Also as occurred in NT, do re-conceptualization and performing change IMs types occur more frequently and with more elaboration in good outcome cases than poor outcome cases?

4. Do the patterns of occurrence of IMs types that emerge across EFT sessions converge with the heuristic model of change drawn from NT? Specifically, do re-conceptualization and performing change IMs increase along treatment?

6. METHOD

6.1. Clients

Clients participated in the York I Depression Study (Greenberg & Watson, 1998), a project designed to assess treatments of major depression comparing 17 process-experiential (also referred as EFT) and 17 Client-Centered Therapy (CCT) treatments. In this study the clients were randomly assigned to one of the two different treatments (EFT or CCT). We studied 6 out of 17 cases assigned to EFT, which had 16 to 20 sessions of individual psychotherapy once a week. These 6 cases were the ones with complete transcripts for intensive process analyses.

Of the six clients in this sample four were women and two were men (age range = 27-63 years, *M* = 45.50 years, *SD* = 13.78). Clients completed an average of 17.50 (*SD* = 1.87) sessions. Five of the clients were married and one was divorced.

Clients were classified as having good or poor outcome based on the analysis of the *Beck Depression Inventory* (BDI; Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) pre- to post-test change scores. BDI is a well-known 21 item self-report instrument to assess symptoms of depression.

A Reliable Change Index (RCI) analysis of BDI pre- to post-test change scores classified three clients as having met criteria for recovered (i.e., passed both a BDI cut-off score of 11.08 and RCI criteria) and the other three clients were classified as unchanged (i.e., have not passed both BDI cut-off score of 11.08 and RCI criteria) at treatment termination (see Jacobson & Truax, 1991; McGlinchey, Atkins, & Jacobson,

2002). More specifically, pre-post BDI scores for the good outcome cases were 25 to 3, 30 to 5, and 35 to 4, whereas for the poor outcome cases was 15 to 13, 23 to 22, and 24 to 18.

6. 2. Therapists

Five therapists conducted the therapeutic process of the six clients analyzed in this study. Four of the therapists were female and one was male. They were of varied levels of education, from advanced doctoral students in clinical psychology to PhD clinical psychologists. Four of the therapists were of Caucasian origin and one was Indian. All therapists received a 24 week training according to the manual devised for the York I Depression study (Greenberg, Rice & Elliott, 1993). The received training consisted of eight weeks of CCT, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue and four weeks for empty-chair dialogue.

6.3. Treatment

Emotion-focused therapists assume the client-centered relational conditions and use experiential and gestalt interventions to facilitate the resolution of maladaptive affective-cognitive processing. These interventions included focusing (Gendlin, 1981) at a marker of an unclear felt sense, systematic evocative unfolding for problematic reactions, two-chair dialogue for self-evaluative and self-interruptive conflict splits and empty-chair dialogue for unfinished business with a significant other (Elliott, Watson, Goldman & Greenberg, 2004; Greenberg, et al., 1993; Greenberg and Watson, 2006).

6.4. Measures

Innovative Moments Coding System

To study the process of change, the cases were coded using the Innovative Moments Coding System (IMCS, Gonçalves, Ribeiro, et al., 2010). Table II - 1 describes how IMs are identified and give examples of the diversity in each type. Studies using IMCS showed a good reliability of the coding system, across therapeutic models and diagnoses (or problems). The average percentage of agreement ranged from 84% to 94% and the average Cohen's Kappa ranged from .80 to .97, showing a strong agreement between judges (Hill & Lambert, 2004).

6.5. Procedures

For the present study, the IMCS was applied to all session transcripts of 6 EFT cases selected from York I Project on Depression Study (Greenberg & Watson, 1998).

All session transcripts from the two outcome groups – three good and three poor outcome cases – were intensively analyzed regarding the emergence of IMs and the specific types of IMs for each session of each case. Therefore, 105 sessions were coded in which 49 sessions fit into the good outcome group and 56 sessions belong to the poor outcome group. The sessions were coded from the transcripts of the cases.

The IMCS coding procedure required data analysis by two raters (first and second authors), that were unaware of the outcome status of the cases. The rater 1 (first author) coded the entire sample and rater 2 (second author) independently coded 50% of the sample sessions (53 sessions). The raters were trained by the authors of the manual (last author). Training included discussing the manual with the authors, coding transcripts from different samples, discussing disagreements and misunderstandings in the process of coding until a consensus was established. At the end of the training

period reliability of raters was assessed by comparing their codes with the codes of expert judges in a set of randomly selected excerpts of dialogues of therapeutic sessions. Raters were considered to be reliable and able to engage in coding research material once they achieved a Cohen's Kappa higher than .75.

Three steps were carried out in the process of coding IMs: (1) A consensual definition of the problems by the two raters, (2) identification of each IM, defining its beginning and end, (3) categorization of previously identified IMs in terms of type and definition of its salience.

6.5.1 Consensual definition of problematic self-narratives by the two raters. The first step of the process of coding therapy sessions involved a careful reading of all psychotherapeutic transcripts. Following this initial procedure, raters independently listed the clients' problems (or themes of the problematic self-narrative), then met and discussed their understanding of what comprised each client's problematic self-narrative. After this discussion, the problems were identified and consensually defined (as close as possible to the client's discourse). To make this procedure clearer we give an example of problematic narrative identified in the case of Lisa, a well-known EFT client from the York I Depression Study sample ("The Case of Lisa", 2008; Gonçalves, Mendes, et al., 2010). One of Lisa's problematic self-narrative themes was "Resentment and difficulty in expressing her own feelings":

> L: *... maybe that's why I don't tell him (husband) how I really feel inside (sniff) ... yeah, there's, or um, even though I express it, it's just kind of laughed at.*

As we already stated, an Innovative Moment (IM) would by definition be an exception to this theme:

> L: *...but then my feelings are my feelings and I'm entitled to them.*

6.5.2. Identification of Innovative Moments. In order to allow raters to track what were IMs, within the client discourse, the sessions were, independently, coded in chronological order. When either therapist or client started to talk about any content that constituted an exception to the client's previously identified problematic self-narrative, raters identify the IM's onset and offset. The IMs contained both client and therapist dialogues, since from our perspective change is co-constructed between therapist and client (Angus, Levitt & Hardtke, 1999). Thus, the IMs could result from questions or tasks suggested by the therapist, but they were only coded as IMs if the client accepts therapists' formulation and elaborates on them. For instance, if the therapist poses a question that contains an IM and the client denies it or does not elaborates it in some way it is not coded.

***6.5.3. Categorization of one of the five types of IMs and definition of its salience*.** After identifying IMs, raters had to identify which type of IMs was present (e.g., action, reflection). In order to measure the degree of IM salience, when we use transcripts (instead of audio/video tapes), as in this study, we use the textual salience index defined as the percentage of words involved in the IM's elaboration. We computed for each client the following measures:

- Textual salience of each type of IM (e.g., action, reflection) for each session;
- Textual salience for overall IMs, independently of the type, for each session. This is a sum of the five types' salience.
- Mean textual salience for the entire treatment, per type and overall IMs.

In the results section findings from IMs are always referring to measures of textual salience.

7. RESULTS

7. 1. Can IMCS reliably identify IM types in EFT therapy transcripts?

Inter-rater agreement on IMs' textual salience was calculated as the overlapping words identified by both raters (rater 1 and 2) divided by the total amount of words identified by either rater. The percentage of agreement on overall IMs textual salience was 88.7%.

For studying inter-agreement on IM type we used Cohen's Kappa, which in this sample was of .86, showing a strong agreement between raters (Hill & Lambert, 2004).

7. 2. Do good outcome cases present higher IM overall salience than poor outcome cases, as it occurred in Narrative Therapy?

In order to assure the homogeneity of the groups we analyzed the differences between the two groups regarding the number of sessions and the scores of BDI at the pre-test. No significant differences between the good and poor outcome cases were found for number of sessions. The level of symptom severity on the pre-test BDI was significantly different between the two outcome groups (U=-1.96, p=.050), with good outcome clients presenting significantly higher (more severity) BDI scores than poor outcome clients.

To test the differences between the two outcome groups in terms of the overall textual salience of IMs (see Figure II - 2), a Mann-Whitney U test was carried out. There was a significant difference between good and poor outcome clients in IMs (U = -1.96, p=.050), with the good group evidencing higher levels of IM textual salience. Good outcome group had a mean of textual salience of IMs of 30.31 (SD= 4.02) and poor-outcome group had a mean of 8.91 (SD= 5.97).Specifically, this means that good outcome cases, as average, spent 30.3% of the sessions elaborating IMs, while poor outcome cases only spent a mean of 8.9%.

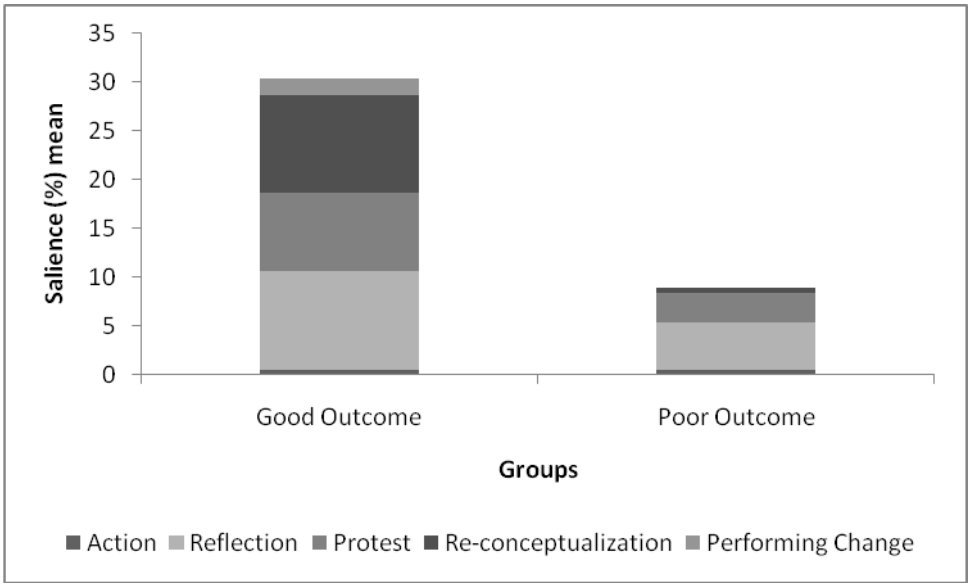

Figure II – 2. Innovative moments in good and poor outcome groups.

7. 3. Do re-conceptualization and performing change IMs distinguish good from poor outcome cases, as it occurred in Narrative Therapy?

Good outcome clients were found to have significantly higher re-conceptualization (*U* =-1.96, p= .050) and performing change (*U* =-2.09, p=.037) IMs than the poor outcome clients. There was no significant differences between good and poor outcome groups on action (*U* = -.22, p=.83), reflection (*U* =-1.53, p=.13) and protest (*U* = -1.09, p=.28) IMs.

7. 4. Does the pattern of evolution of re-conceptualization and performing change IMs, across sessions, support the heuristic model of change?

Since re-conceptualization and performing change were the IM types revealing differences between groups we have considered, for each group, a non-parametric smooth to summarize the trend of the response variable as a function of treatment session. Figure II - 3 shows the evolution of re-conceptualization IMs in good and poor outcome cases and figure II - 4 shows the evolution of performing change IMs in good

outcome cases (performing change is absent in poor outcome cases). The black solid line in the plot represents the non-parametric smooth spline of the observed data (Keele, 2008) with respective 95% confidence intervals, within each outcome group. The advantage of such smoother is that we do not have to impose any rigid form for such function. The non-parametric smoothing spline emerges as a solution of an optimization problem, of minimizing simultaneously the residual sum of squares and second derivative of such a function (Hastie & Tibshirani, 1990). Clearly, the evolution of both IMs reflects an increasing profile.

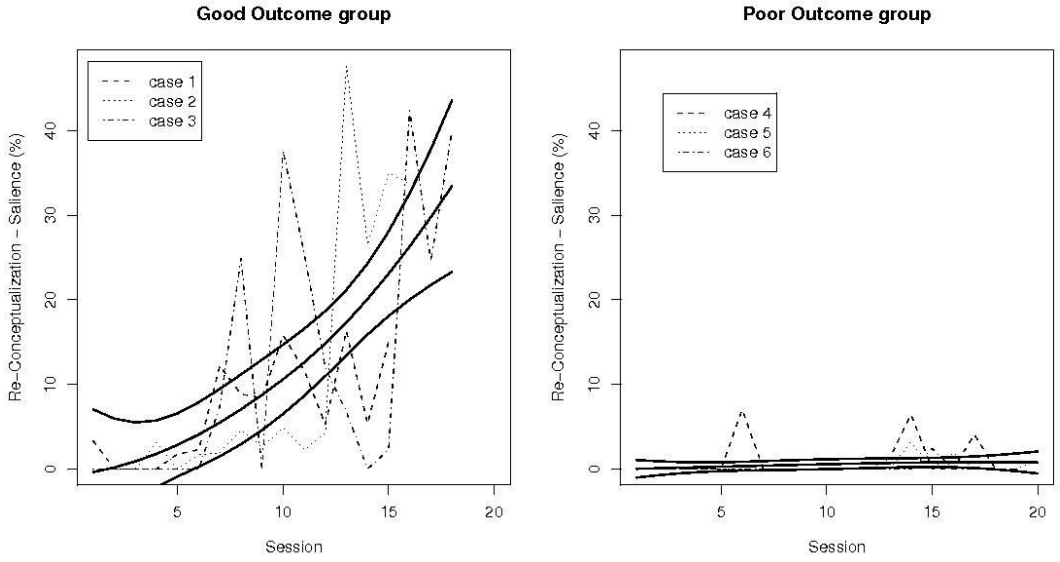

Figure II – 3. Evolution of re-conceptualization IMs in good and poor outcome cases.

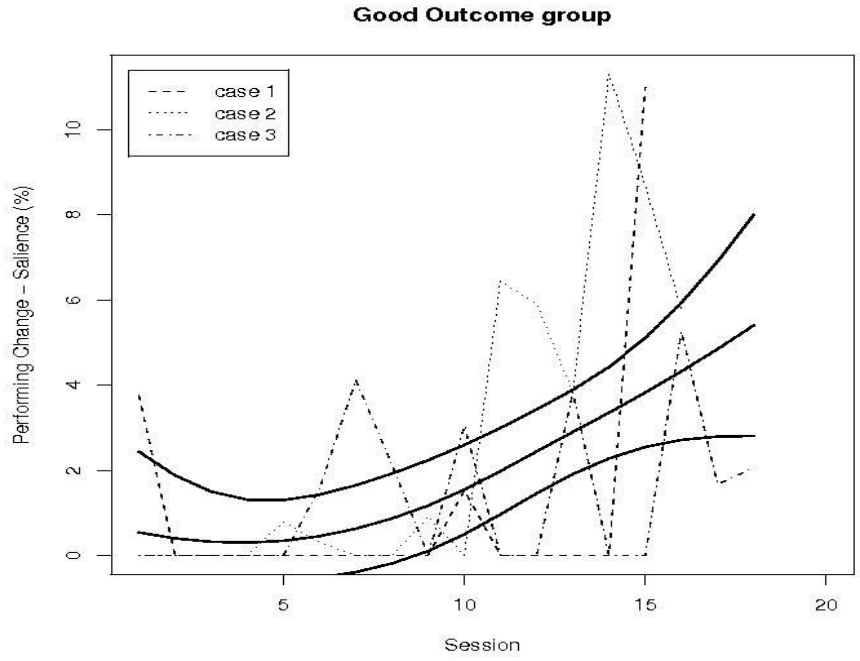

Figure II – 4. Evolution of performing change IMs in good outcome cases.

8. DISCUSSION

These findings suggest that IMCS can reliably identify the different IM types in EFT therapy transcripts, and may be used as an effective method for the identification and tracking of client narrative change. Thus, IMCS allows studying change in EFT, in which the concept of IM does not play a central role among the assumptions and techniques that guide the therapist. Furthermore, the emergence and development of IMs globally replicates the findings from NT (Matos et al., 2009), corroborating the heuristic model of change summarized previously.

Overall textual salience of IMs is higher in good outcome cases, suggesting that the increased narrative elaboration of IMs may be associated with therapeutic change. With low action, almost no re-conceptualization and absence of performing change IMs, poor outcome cases have almost only reflection and protest IMs throughout therapy. On the contrary, in good outcome cases all the IMs are present. Moreover, good outcome cases

have a significantly higher elaboration of re-conceptualization and performing change IMs, as reflected in the increased textual salience. These types of IMs also have a clearly increasing trend in good outcome cases (different from poor outcome cases, in which the trend is stable), as evidenced by the smoothing spline analysis. These differences between groups, in overall IMs and in re-conceptualization and performing change, replicates the findings of the narrative sample (Matos et al., 2009) as well as the ones from several cases studies (Gonçalves, Mendes, et al., 2010; Ribeiro et al., 2009), also being congruent with the model of narrative change previously presented, as far as the importance of re-conceptualization and performing change IMs in therapeutic change is concerned. It seems that re-conceptualization and performing change IMs play a role in successful emotion-focused therapy for depression. We speculate that with the emergence of re-conceptualization the client is engaged in a self-empowered position that provides the scaffolding of the client's authoring of his or her new self-narrative. The emergence of re-conceptualization IMs unfold the client's sense of authorship, emphasizing that a new narrative of the self is developing. In the introductory section several hypothetical reasons were advanced on why re-conceptualization might be a core IM in successful therapy, such as being an IM that 1) articulates past with present, allowing for an integration of the problematic narrative into a new self-narrative; 2) positions the client as an author of his or her own experience; and 3) allows for the organization of the more elementary types of IMs (action, reflection and protest) (Gonçalves, Santos, et al., 2010; Matos et al., 2009). The narrative model of change summarized in the introduction suggests that performing change IMs may be an extension into the future of the change present in re-conceptualization IMs. Clearly, the reasons why re-conceptualization seems so vital in the change process need to be deeply analyzed with different methodological approaches (e.g., task analysis), but this study

confirms once again its centrality in the change process, along with performing change IMs (see Matos et al., 2009 for a discussion on the importance of re-conceptualization IMs and its relation with other concepts, as insight or meta-cognitive functions).

One important difference from the pattern of IMs found in NT (Matos et al., 2009) is the low presence of action IMs, not only in poor outcome, as well in good outcome cases. Also, although performing change is significantly higher in the good outcome group, and completely absent in the poor outcome group, it is almost half of what was found in the NT sample (EFT – 1.72%; NT; 3.34%). Previous research (Santos et al., 2009) has suggested that the 5 types of IMs clustered around two dimensions: one of action (action and performing change IMs) and one of meaning (reflection, protest, and re-conceptualization IMs). Thus, the results found in EFT, although globally replicating the results found in NT, suggest that EF therapists and clients privilege the meaning side of innovation's production. This finding is congruent with the assumptions of EFT (Greenberg & Watson, 2006), that favours the emotional experiencing and elaboration instead of promoting innovative actions, outside the therapeutic setting.

These results, thus, suggest that the main pattern of results in NT and EFT is similar: higher IMs elaboration in good outcome cases, higher re-conceptualization and performing change in good outcome cases. However, the IMs coding system also seems to capture some specificities of the therapeutic model: lower action and performing change when compared with NT. From these results, we speculate that the IMCS captures similarities between the two therapies, as well some more superficial differences. Future research with other therapeutic models will inform us if theses similarities persist and if other specificities of different therapeutic models emerge with IMCS studies.

Since therapists, despite their theoretical background, search for novelties in the re-construction of their clients problematic experiences, the replication of the data from NT (Matos, et al., 2009) is not a complete surprise, although EFT therapists are focused in several dimensions of clients' lives other than unique outcomes (or IMs), which are clearly an important target for narrative therapists. For an EFT therapist, emotional processing is much more important than identifying and expanding exceptions to the problematic self-narrative. However it seems that this elaboration of the emotional experience reflects closely what occurs in NT, in terms of IM development. In this sense, we may hypothesize that engagement in experiential therapeutic interventions in EFT facilitates clients' emotional processing and, through this, may foster the development of IMs. Along these lines, we are suggesting that the elaboration of IMs could be the outcome of diverse therapeutic activities, from narrative questioning (White & Epston, 1990; White, 2007) to experiential therapeutic strategies, like chair work (Elliott, Watson, Goldman, & Greenberg, 2004).

The size of the analyzed sample is one of the major limitations of the present study making its conclusions limited and exploratory. However this study demonstrates the applicability of IMCS to a different therapeutic model and a different sample of clients. Another limitation is the difference found between poor and good outcome cases in the pre-test BDI, as some of the change in BDI scores could be explained by a regression to the mean (Cook & Campbell, 1979). However the differences in the scores and the RCI (see Jacobson & Truax, 1991; McGlinchey, Atkins, & Jacobson, 2002) do suggest that these changes were in fact clinically meaningful.

Finally, at this point of our research program we cannot be sure that IMs are mediating variables of change. They can be outcome variables, and if so, there would be a kind of circularity in these results: good outcome cases (as assessed by the BDI) have

a higher presence of IMs (another form of in-session outcome assessment). Other research designs are needed to test if IMs are mediating variables or outcome variables (see Kendall, Holmbeck, & Verduin, 2004). However, as we argued before (Matos et al., 2009) even if IMs are outcome variables they could be a useful tool to study how intermediate outcomes develop within therapeutic sessions.

Future research with the IMCS can have important clinical implications, showing how therapists elicit and sustain the elaboration of IMs in good outcome cases and fail to do so in unsuccessful therapy.

9. REFERENCES

Angus, L., & McLeod, J. (Eds.) (2004). *The handbook of narrative psychotherapy: Practice, theory and research*. London: Sage.

Angus, L., Levitt H., & Hardtke, K. (1999). The narrative processes coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology, 55*, 1255-1270.

Baerger, D. R., & McAdams, D. (1999). Life story coherence and its relation to psychological well-being. *Narrative Inquiry, 9*, 69-96.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Cook, T. D., & Campbell, D. T. (1979). Quasi-experimentation: Design and analysis issues for field settings. Boston, MA: Houghton Mifflin Company.

Dimaggio, G. (2006). Disorganized narratives in clinical practice. *Journal of Constructivist Psychology, 19*, 103-108.

Elliott, R., Watson, J. C., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: the process-experiential approach to change*. Washington, DC: American Psychological Association.

Gendlin, E. T. (1981). *Focusing* (2nd ed). New York: Bantam Books.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology, 22*, 1–23.

Gonçalves, M. M., Mendes, I., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology, 23,* 1 - 28.

Gonçalves, M. M., Ribeiro, A., Matos, M., Santos, A., & Mendes, I. (2010). The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & A. Gennaro (Eds.), *YIS: Yearbook of Idiographic Science 2009 - Volume 2*. Rome: Firera Publishing Group.

Gonçalves, M. M., Santos, A., Matos, M., Salgado, J., Mendes, I., Ribeiro, A., Cunha, C. & Gonçalves, J. (2010). Innovations in psychotherapy: Tracking the narrative construction of change. In J. D. Raskin, S. K. Bridges, & R. Neimeyer (Eds.), *Studies in meaning 4: Constructivist Perspectives on Theory, Practice, and Social Justice* (pp. 29 - 64). New York: Pace University Press.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client–centred relationship conditions and process interventions. *Psychotherapy Research, 8*, 210–224.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-Focused Therapy for Depression*. Washington: American Psychological Association.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process*. New York: The Guilford Press.

Hastie, T. & Tibshirani, R. (1990). *Generalized additive models, Volume 43 of Monographs on statistics and applied probability*. London: Chapman & Hall.

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert, (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change (5th Ed.)* (pp. 84 - 135). New York: John Wiley & Sons, Inc.

Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12–19.

Keele, L. (2008). *Semiparametric regression for the social sciences*. New York: John Wiley and Sons.

Kendall, P., & Holmbeck, G., & Verduin, T. (2004).Methodology, design, and evaluation in psychotherapy research In M. J. Lambert (Eds), *Bergin and Garfield's handbook of psychotherapy and behavior change (5th ed.)* (pp. 16-43) New York: John Wiley & Sons.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

McGlinchey, J.B., Atkins, D.C., & Jacobson, N.S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy, 33,* 529–550.

Ribeiro, A.P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de

mudança em psicoterapia: Estudo de um caso de sucesso de terapia constructivista [Narrative change processes in psychotherapy: A case-study of successful constructivist therapy]. *Psychologica, 50, 181-203.*

Santos, A., Gonçalves, M. M., & Matos, M. (2010). Innovative Moments and Poor-outcome in Narrative Therapy. Counselling and Psychotherapy Research. DOI: 10.1080/14733140903398153

Santos, A., Gonçalves, M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449-466.

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3–21). New York: Praeger.

The Case of Lisa [Special Section] (2008). *Psychotherapy Research, 18* (6).

White, M. (2007). *Maps of narrative practice*. New York: Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

CHAPTER III

NARRATIVE CHANGE IN CLIENT-CENTERED THERAPY AND EMOTION FOCUSED THERAPY: A COMPARATIVE STUDY

CHAPTER III

NARRATIVE CHANGE IN CLIENT-CENTERED THERAPY AND EMOTION FOCUSED THERAPY: A COMPARATIVE STUDY[3]

1. ABSTRACT

Objectives. This study aims to extend the research program with the *Innovative Moments Coding System* (*IMCS*) to Client-Centered Therapy (CCT). One other focus is to compare the patterns of *Innovative Moments* (*IMs*) between CCT and Emotion-Focused Therapy (EFT). **Methods:** The IMCS was used to code the emergence of different types of IMs (action, reflection, protest, re-conceptualization and performing change) in 198 sessions from both CCT and EFT samples. **Results:** The results from the CCT sample revealed significantly more IMs and specifically more re-conceptualization and performing change IMs in good outcome cases. The comparison between CCT and EFT showed that EFT presented significantly more protest IMs. **Conclusion:** The similarity between CCT and the other therapeutic modalities studied so far could reflect a pattern of innovation's development common to brief therapy.

2. INTRODUCTION

The narrative approach to psychotherapy assumes that clients transform themselves by changing their self-narrative along the therapeutic process (White & Epston, 1990; White, 2007; see Angus & McLeod, 2004). This study departs from the assumption that the research of the self-narrative transformations that occur throughout psychotherapy constitutes a window into the process of change.

[3] This work was submitted to the journal *Psychotherapy Research*, in co-authorship with Miguel M. Gonçalves, Inês Mendes, Graciete Cruz, Antonio P. Ribeiro, Lynne E. Angus and Leslie S. Greenberg.

This study has two aims: (1) to describe the narrative process of change in Client-Centered Therapy (CCT), according to the *Innovative Moments Coding System* (*IMCS*; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; see also Gonçalves, Matos, & Santos, 2009); (2) and to compare the results obtained in this sample with a sample of Emotion-Focused Therapy (EFT), both from the York I Depression Study (Greenberg & Watson, 1998). The EFT sample was previously studied with the IMCS (Mendes, Ribeiro, Angus, Greenberg, Sousa, & Gonçalves, in press).

Innovative moments (or *IMs;* also named as *i-moments* in previous studies) are all occurrences (thoughts, actions and feelings) outside the influence of the problematic self-narrative, constituting exceptions, and being this way potential movements in the construction of a new self-narrative (Gonçalves et al., 2009; Matos, Santos, Gonçalves, & Martins, 2009). Problematic self-narratives can be conceived as a set of rules of behaving, feeling and thinking (as it occurs for instance in depression) and IMs are all the times these rules are somehow challenged and exceptions occur. Problematic self-narratives are equivalent to the concept of cognitive schema in cognitive therapy (Beck, 1976), defined as a " cognitive structure for screening, coding, and evaluating the stimuli that impinge on the organism" (Beck, 1976, p. 233) and core constructs in constructivist therapies, defined as abstract and frequently universalized meanings that play critical organizing roles for the entirety of our construct systems, ultimately embodying our most basic values and sense of self (Kelly, 1955; Mahoney, 1991). Bearing this analogy in mind, an IM is every time the problematic self-narrative is challenged and the client feels, thinks, and/or acts differently than one might expect, from the regular functioning. For instance, if the problematic self-narrative is characterized by devaluation of own needs and privileging other's wishes (e.g., "there's a lot of making me feel like I'm a bad person. And I've just got to keep on trying, just

accept him (husband) the way he is and just shut-up."), an IM would be all the times the person values his or her own needs, emerging in the forms of thoughts, action or feelings (e.g., "I don't want to live like that anymore, I want to be able to enjoy life, to let out my creativity… I deserve that.").

To perform the analysis of the process of change, this study uses the IMCS (Gonçalves, Ribeiro, et al., 2010) to track IMs in psychotherapy sessions. This method identifies five different types of IMs – *action*, *reflection*, *protest*, *re-conceptualization* and *performing change* – highlighting their role in the construction of preferred self-narratives.

- Action IMs are specific behaviors that challenge the problematic self-narrative.
- Reflection IMs are thoughts, feelings, intentions, projects or other cognitive products that challenge the problematic self-narrative.
- Protest IMs entail new behaviors (like action IMs) and/or thoughts (like reflection IMs) that challenge the problematic self-narrative, representing a refusal of its assumptions. This active refusal is the key feature that allows distinguishing protest from action and reflection.
- Re-conceptualization IMs are the most complex type of innovations. The client not only describes some form of contrast between present and past (e.g., "now I've changed X or Y"), but he or she also understands the processes that allowed for this transformation.
- Performing change IMs (previously named as new experiences) IM are new aims, experiences, activities or projects, anticipated or in action, as a consequence of change (see table III - 1).

Table III – 1. IMs with examples. From *The Innovative Moments Coding System: A coding procedure for tracking changes in psychotherapy*, by M. M. Gonçalves, A. P. Ribeiro et al., 2010. Adapted with permission.

	Contents	Examples (Problematic narrative: depression)
Action	• New coping behaviors facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control ; • Searching for information about the problem(s).	C: Yesterday, I went to the cinema for the first time in months!
Reflection	***Creating distance from the problem(s)*** • Comprehension – Reconsidering problem(s)' causes and/or awareness of its effects; • New problem(s) formulations; • Adaptive self instructions and thoughts; • Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being. ***Centered on the change*** • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies; implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	C: I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go… C: I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it.
Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s). ***Emergence of new positions*** • Positions of assertiveness and empowerment;	C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!? C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.

Re-conceptualization	RC always involve two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs… T: How did you have this idea of going to the museum? C: I called my dad and told him: we're going out today! T: This is new, isn't it? C: Yes, it's like I tell you… I sense that I'm different…
Performing Change	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource to new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	T: You seem to have so many projects for the future now! C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.

Several studies, using quantitative, qualitative and mixed designs, have been lead applying IMCS to analyze the process of change in brief psychotherapy with different populations and therapeutic modalities. Both hypothesis-testing studies with samples (Matos, et al., 2009; Mendes, et al., in press) and intensive single-case studies (Ribeiro, Gonçalves, & Ribeiro, 2009; Santos, Gonçalves, & Matos, 2010; Santos, Gonçalves, Matos, & Salvatore, 2009; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010) showed that IMs emerge both in poor and good outcome cases. Moreover, no significant differences were found in these studies between poor and good outcome cases in relation to action, reflection, and protest IMs, whereas re-conceptualization and performing change present an increasing tendency from middle therapy until termination in the good outcome group. Re-conceptualization is, in good outcome cases, usually the IM more dominant in the final phase of therapy. Re-conceptualization and

performing change IMs appear to play an important role in good outcome cases and they may be necessary for the client's self-narrative change to occur. Usually these IMs are absent or have a very low presence in poor outcome cases.

From these studies a heuristic model of narrative change was developed for successful brief therapy. According to this model change initiates with action and reflection IMs, representing new events and new thoughts outside the influence of the problematic self-narrative that brought the client to therapy. These types of IMs are very important in the beginning because they demonstrate that something different from the problematic self-narrative is occurring (Gonçalves et al., 2009).

Protest IMs may appear alongside action and reflection IMs since the beginning of therapy, or they may emerge after some cycles of action and reflection IMs. These IMs represent the refusal of the assumptions of the problematic self-narrative, which enables the client to reposition him or herself towards the problem and other people that may support it, assuming a position of assertiveness and agency in the process of self re-construction.

Re-conceptualization usually only emerges in the middle of therapy and increases until its termination. Re-conceptualization is central in sustaining meaningful change, giving coherence to the other more episodic novelties that emerged, as action, reflection or protest IMs. According to this model re-conceptualization achieves this purpose by articulating the past with the present (to code re-conceptualization this contrast must be present). Another central feature of re-conceptualization is the presence of some form of change process' description, which allows for the client to position him or herself as the *author* of change. That is, the novelty is not just something that happened; it is something that the client is responsible for. This component of re-conceptualization is

akin to what others researchers call a meta-position (see Dimaggio, Salvatore, Azzara, & Catania, 2003), which seems to be vital in the process of change.

As the client narrates these transformations (during re-conceptualization IMs) more action, reflection and protest IMs emerge consolidating the previous re-conceptualization. Action, reflection, protest on the one side and re-conceptualization on the other are related in a bidirectional way: in the beginning action, reflection and protest operate as signs of change, prompting the emergence of re-conceptualization , in the middle of therapy, and as re-conceptualization emerges, new IMs of action, reflection and protest are elaborated reinforcing the re-conceptualization IMs.

After some of these cycles, performing change emerges and expands the change process into the future, making it clear for the client and to the significant others that this new self-narrative has a future (see Figure III - 1).

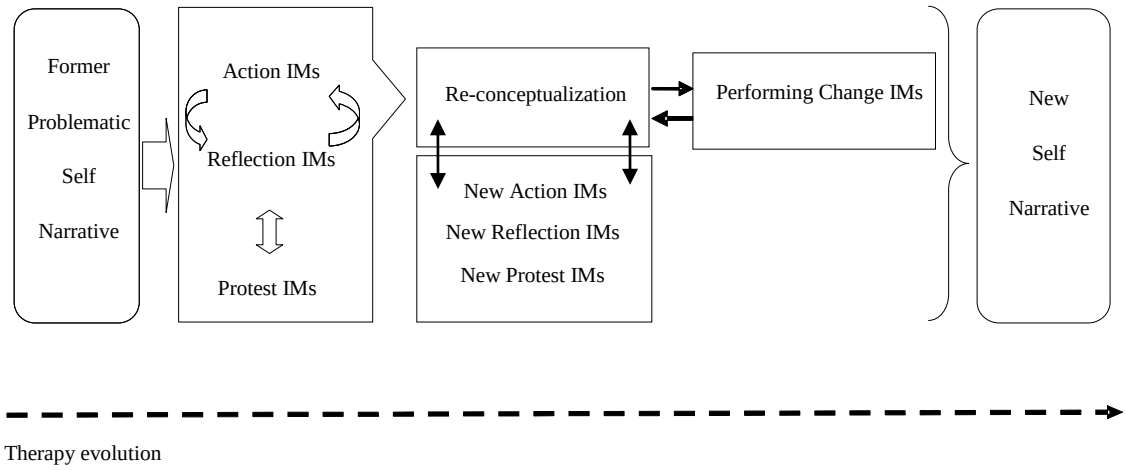

Figure III – 1. Innovative moments' heuristic model of change in psychotherapy drawn from Narrative Therapy.

Until now studies with IMCS were developed with samples of NT with women who were victims of intimate violence (N=10; Matos, et al., 2009) and EFT with clients with major depression (N=6; Mendes, et al., in press). The current study intends to analyze another type of psychotherapy – CCT. In addition, given that both EFT and CCT belong to the same project – York I Depression Study – and are based in the same relational therapeutic conditions, this study compares the development of IMs throughout therapy in these two samples. EFT, as CCT, also emphasizes the same fundamental relational therapeutic conditions, but it too integrates gestalt and experiential interventions (e.g., two-chair dialogues, empty-chair dialogue, systematic evocative unfolding, focusing) (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006).

The design of the present study is similar to the one performed with the EFT sample consisting of a replication of Mendes et al.'s (in press) study on how IMs develop throughout the therapeutic process. This approach is used "to test the generalizability of observations" (Hilliard, 1993 in Knox, Hill, Hess, Crook-Lyon, 2008, p.201). Therefore, the study of the CCT sample with the IMCS is expected to help us validate and consolidate the previously presented heuristic model of narrative change. The following research questions organize this study:

1. Is the IMCS applicable to CCT?
2. What is the IM's pattern in CCT good outcome cases and poor outcome cases? Does this pattern replicate what was found with the previous samples and cases studies, and does it support the model of change referred to before?
3. Given the similarity of the CCT and EFT samples (major depression, same site, same therapists, same central therapeutic principles) what are the major differences and similarities between these samples in IMs development?

3. PRESENT STUDY

As EF therapists, CC therapists are not guided by the narrative metaphor of psychotherapy. So, this study is a further test to the flexibility of the method proposed by the IMCS, given that it is the first time that this method is applied to CCT.

A main goal of this research is to study IMs' development in CCT. We hypothesize that the general pattern of CCT would be similar to the one found in EFT (Elliott, et al., 2004; Greenberg, et al., 1993) and NT, and predicted by the model of change presented before:

a) Higher presence of IMs in good outcome cases;
b) Higher presence of re-conceptualization and performing change IMs in good outcome cases.
c) Poor outcome cases mainly with action, reflection and protest IMS and good outcome cases with all types of IMs.
d) In good outcome cases action, reflection and protest more present until the middle phase when re-conceptualization and performing change IMs emerge increasing until the end of therapy.

Another main goal of the present research is the comparison between EFT and CCT. We expect that no major differences will emerge in this comparison, being both models characterized by the same patterns of IMs development.

4. METHOD

4.1 Clients

Clients were part of the York I Depression Study (Greenberg & Watson, 1998), a project designed to assess treatments of major depression comparing 17 process-

experiential (PE; also referred as EFT) and 17 client-centered (CCT) treatments. In this study the clients were randomly assigned to one of the two different treatments (EFT or CCT) for 16 to 20 sessions of individual psychotherapy once a week. In the present study, 12 therapeutic cases were analyzed: 6 cases from EFT and the other 6 cases from CCT. These 12 cases were the ones with complete transcripts and data set for intensive process analyses. Of the twelve clients gathering EFT and CCT sample, ten were women and two were men (age range = 27-63 years, *M* = 44.25 years, *SD* = 12.07). Clients completed an average of 16.42 (*SD* = 1.98) sessions. Two of the clients were not married and the other ten clients were married.

The constitution of outcome groups was based on the analysis of the BDI pre- to post-test change scores. The Beck Depression Inventory (Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a well-known 21 item self-report instrument to assess symptoms of depression. Scores above 16 were regarded as showing depression and below 10 as falling into the normal population range. This criterion identified three cases in the good outcome group as having met criteria for recovered (i.e., passed a BDI cut-off score of ≤10) and the other three cases were classified as unchanged (i.e., have not passed a BDI cut-off score of ≤10) at treatment termination (see Greenberg & Watson, 1998 for a detailed revision regarding groups' definition).

4.2 Therapists

Eight therapists conducted the therapeutic process of the twelve clients analyzed in this study. Six of the therapists were female and two were male. They were of varied levels of education, from advanced doctoral students in clinical psychology to PhD clinical psychologists. All therapists received a 24-week training according to the

manual devised for the York I Depression study (Greenberg, Rice & Elliott, 1993). The received training consisted of eight weeks of CCT, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue and four weeks for empty-chair dialogue.

4.3 Treatments

CCT. Therapists adopt three core relational attitudes of empathy, unconditional positive regard and congruence. The treatment involves a safe, supportive environment and the therapists' mode of engagement is empathic understanding and validation of client's internal frame of reference. The client's emotional symbolization of affect and core meanings facilitates the access to adaptive emotions and responses. The CCT treatment was conducted according to a manual (Greenberg, Rice, & Watson, 1994) to supplement the readings of Rogers (1951, 1975).

EFT. The emotion-focused orientation conceptualizes the relational CCT conditions as unconditional positive regard, empathy and congruence integrated with gestalt interventions to facilitate the resolution of clients' current affective-cognitive problem states. In EFT the access of core maladaptive schemes and the experience of disclaimed emotions increase emotional awareness, which facilitates the emergence of new adaptive emotional responses and new meanings (Greenberg, et al., 1993; Elliott, et., 2004).

4.4 Measures

The analysis of the process of change involved the coding of these 12 cases using the IMCS (Gonçalves, Ribeiro, et al., 2010). The identification of IMs and its respective examples are described in Table III - 1.

4.5 Procedures

For the present study, the IMCS was applied to all sessions of the 6 cases from the CCT clients of the York I Project on Depression Study (Greenberg & Watson, 1998; Greenberg & Angus 1994). The analysis of the 6 EFT cases with the IMCS was previously performed (Mendes, et al., in press).

In the study of EFT 105 sessions, of which 49 sessions belong to the good outcome group and 56 sessions fit into the poor outcome group, were coded using IMCS. Similarly, in the present study, both CCT outcome groups – three good and three poor outcome cases – were intensively analyzed regarding the emergence of IMs. Therefore, 93 sessions were coded, of which 46 sessions fit into the good outcome group and 47 sessions belong to the poor outcome group.

The coding procedure required data analysis by two raters (second and third authors), unaware of the outcome status of the cases. In this sample rater 1(third author) coded the entire sample and rater 2 (second author) coded 30% of the sample.

Four steps were carried out in the process of coding IMs (both in EFT and CCT samples): (1) Training, (2) a consensual definition of the problems by the two raters, (3) identification of each IM, defining its onset and offset in the transcripts, for purposes of tracking the proportion of the session occupied by IMs (index of salience, see below) and (4) categorization of previously identified IMs in terms of type.

***4.5.1. Training*:** The raters were trained by the authors of the manual and during this period they had weekly meetings with all members of the research team that were also being trained. Between meetings they coded psychotherapy transcripts. The process of training included discussing the manual with the authors, coding transcripts from different samples, discussing disagreements and misunderstandings in the process of coding until a consensus among every member was established. At the end of the

training period reliability of the raters involved in the analysis of EFT and CCT samples was assessed by comparing their codes with the codes of expert judges in a set of randomly selected excerpts of dialogues of therapeutic sessions. Raters were considered to be reliable and able to engage in coding research material since they achieved a Cohen's Kappa higher than 0.75.

***4.5.2. Consensual definition of the problems by the two raters*:** The first step of the process of coding involved a careful reading of the entire psychotherapeutic transcripts. Following this initial procedure, raters independently listed the client's problems (or themes of the problematic self-narrative) and then met and discussed their comprehension of clients' problematic self-narratives. After this discussion, the problems were consensually defined (as close as possible to the client's self-narrative).

4.5.3. Identification of IMs: In order to allow raters to track what were IMs, within the client discourse, the sessions were, independently, coded in the order they occurred. Raters coded IMs from the transcript, when either therapist or client started to talk about any content that constituted an exception to the client's problematic self-narrative, identifying each IM's onset and offset. IMs contained both client and therapist turn taking, since from our perspective change is co-constructed between therapist and client (Angus, Levitt & Hardtke, 1999). Thus, the IMs could result from questions or tasks suggested by the therapist, but they were only coded as IMs if the client accepts the therapists' formulation and elaborates on them. For instance, if the therapist poses a question that contains an IM and the client denies it or does not elaborate on it in some way it is not coded.

To measure the proportion of the sessions occupied by IMs we use a measure of time when we work with audio or video and a measure based upon the amount of text when we work with transcripts, as we have done in this study (and also in the previous

study with EFT). We named this measure of proportion as salience, specifying if it is temporal salience, as in the first case, or textual salience, as in the second one.

Textual salience was computed for each of the five types of IMs (the percentage of words in the session occupied by that specific type of IM), as well as the mean textual salience of each type throughout the process. We also computed the overall textual salience of IMs as the total percentage of words involved in IMs.

Inter-rater agreement on textual salience was calculated as the overlapping words identified by both raters divided by the total text identified by either rater.

***4.5.4. Categorization of IMs' types*:** After identifying IMs and their textual salience, raters had to, independently, identify which type of IMs were present (e.g., action, reflection). As described in the results, given the high inter-rater reliability, we based our analyses upon rater 1's coding.

5. RESULTS

We divided this section in three subsections: 1) the study of IMs in EFT, in which we briefly revise the results from the previous study; 2) the study of IMs in CCT, examining how they emerge in this sample; and 3) the comparison between CCT and EFT, analyzing if there are significant differences between the two samples.

5.1. IMs in EFT

In the EFT sample IMs emerged in both outcome groups but presented a significant higher textual salience in the good outcome group (M= 30.31, SD= 4.02; poor outcome group: M= 8.91; SD= 5.97). In the good outcome group, reflection presented a stable development throughout therapy. Protest IMs increase until the middle phase and then decrease until the end. Re-conceptualization IMs emerged during the working phase of

therapy and increased until the end of the therapeutic process. Performing change IMs appeared in a modest way until the final phase where they presented a more expressive textual salience. The poor outcome group reveals a different developmental pattern of IMs with lower textual salience of IMs and less diversity of IMs types. Reflection and protest IMs were the ones with higher textual salience since the beginning and until the end of therapy. Re-conceptualization IMs also appear in this group but with a much reduced textual salience (less than 1%). Performing change IMs were absent in this outcome group (see Mendes, et al., in press for a detailed review on the IMs developmental pattern in EFT) (Figure III - 2).

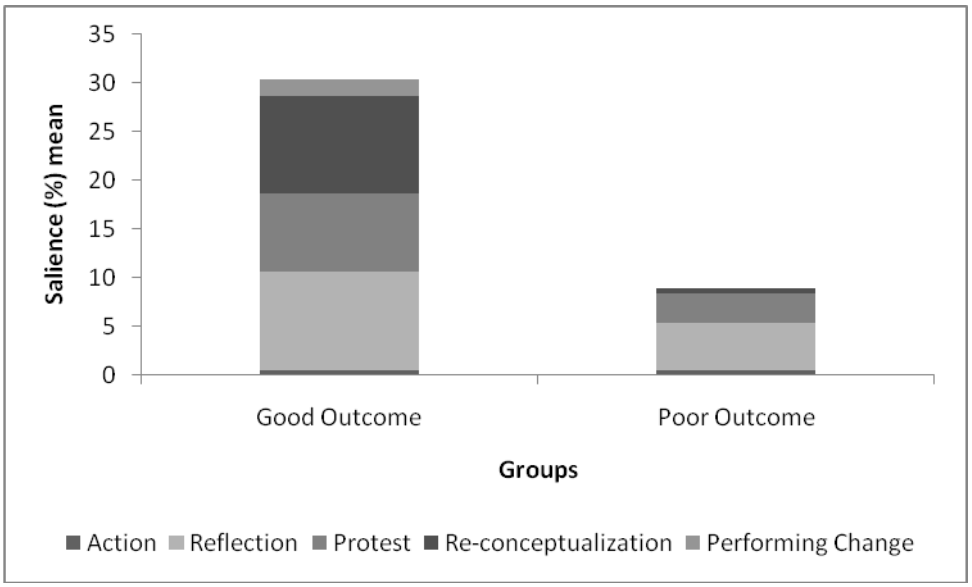

Figure III – 2. Innovative moments in good and poor outcome groups in EFT.

5.2. IMs in CCT

5.2.1 Reliability

The percentage of agreement between the two raters on overall IMs textual salience was 86% and the Cohen's Kappa of the different types of IMs was .97. This means that

the raters agree 86% of the text about the presence or absence of IMs and when the IMs were identified the agreement regarding the type was very high.

5.2.2. Differences Between Good and Poor Outcome Groups in CCT.

Following Mendes and collaborators' (in press) analytical strategy, in order to assure the homogeneity of the groups, we analyzed the differences between the two groups regarding the number of sessions and the symptoms at the pre-test BDI. No significant differences on BDI scores were found between the good and poor outcome groups, U=3.50, p=.65. Likewise, no group differences were found on the number of sessions, U=2.00, p=.28.

A Mann-Whitney U test was computed to test for differences between outcome groups regarding the overall textual salience of IMs as well as the different types of IMs (Figure III - 3). There was no significant differences between good and poor outcome groups on the overall textual salience of IMs, U=2.00, p=.28. Good outcome clients had a mean textual salience of IMs of 11.13 (SD= 5.5) and poor outcome cases had a mean of 5.82 (SD= 3.74). On the topic of IMs specific types, the good outcome group presented a significantly higher textual salience of re-conceptualization IMs, U=.00, p=.05, and performing change IMs, U=.00, p=.05. No group differences were found in action, reflection and protest IMs.

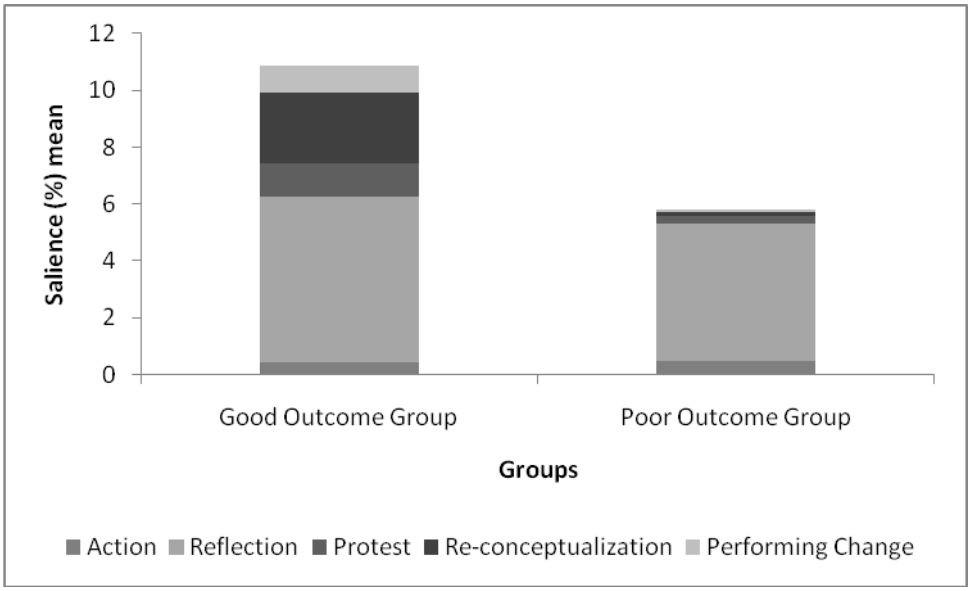

Figure III – 3. Innovative moments in good and poor outcome groups in CCT.

5.2.3 IMs emergence throughout the process.

In the good outcome group, action IMs were constant throughout the therapeutic process exhibiting low values of textual salience. Reflection IMs presented high textual salience in all the therapeutic phases being stable across the entire therapy. In the middle phase, all the types of IMs were present. Protest IMs increased slightly in this phase and decreased in the final one. Re-conceptualization IMs were present in a more expressive way during the working phase and increased considerably in the final phase of therapy. Performing change IMs emerged in the middle phase increasing at termination. Figure III - 4 shows the evolution of IMs throughout the process.

The poor outcome group presents less diversity of IMs types and lower values of textual salience all through the entire therapeutic process. Reflection IMs were, once again, the type that presents higher textual salience and it was constant since the beginning until the end of therapy. Action and protest IMs emerged in all therapeutic phases but with a reduced textual salience. Also with a much reduced textual salience

were re-conceptualization and performing change IMs. Moreover, these two types only appeared at the end of therapy (see Figure III - 5).

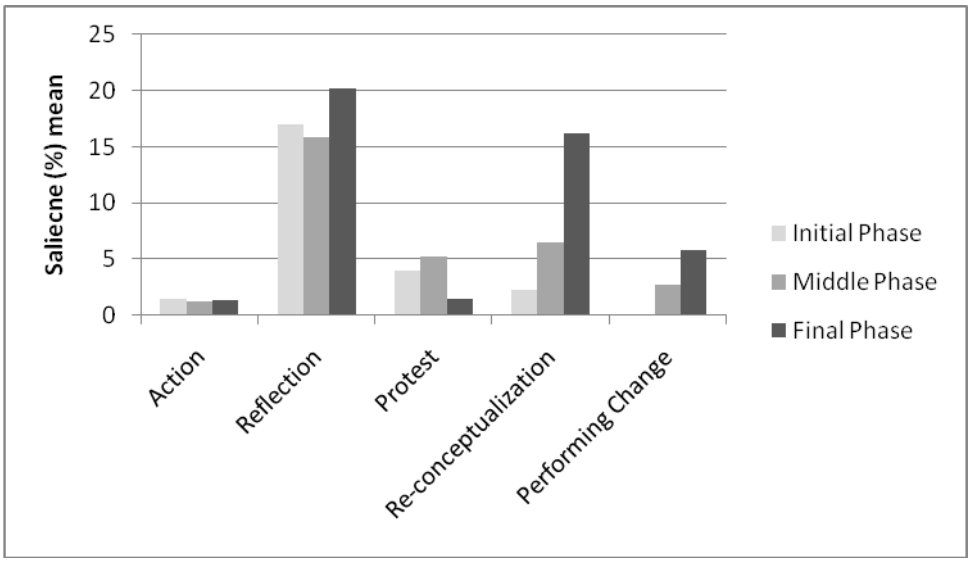

Figure III – 4. Innovative moments through therapeutic phases in good outcome group in CCT.

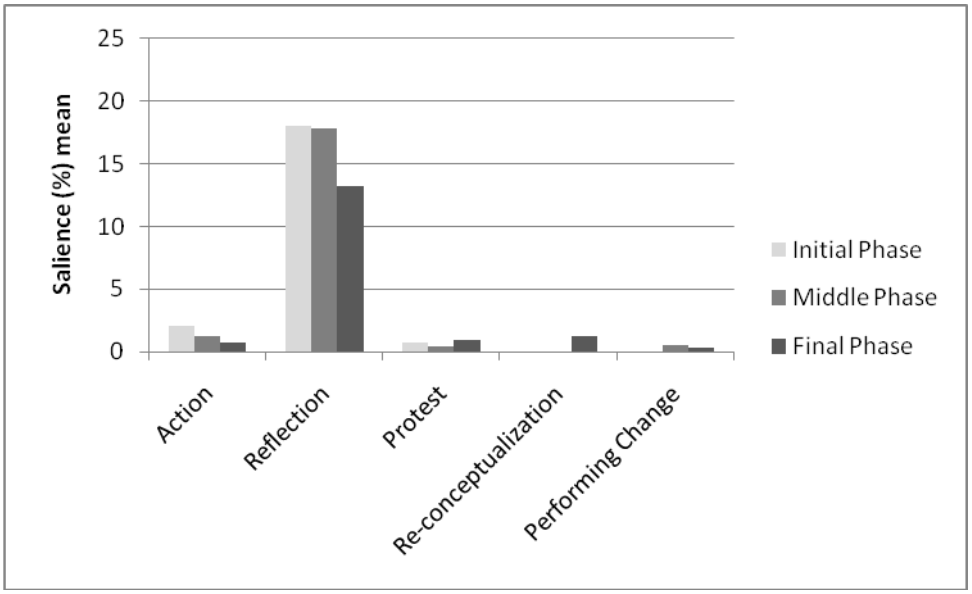

Figure III – 5. Innovative moments through therapeutic phases in poor outcome group in CCT.

5.3. Comparing CCT with EFT

5.3.1. Differences between therapeutic modalities. No group differences were found in the symptoms at the pre-test BDI, $t(10)=-7.49$, $p=.47$.

The number of sessions varied from 15 to 20 in the EFT group and from 13 to 18 in the CCT group, but the mean number of sessions was not significantly different, $t(10)=-1.75$, $p=.11$. Therefore, there was no need to use the number of coded sessions as a covariate.

To compare the two samples (CCT and EFT) we used parametric tests and confirmed that our conclusions would not change when applying non-parametric tests, as proposed by Fife-Schaw (2006).

A *t* test was carried out to test for differences between groups in the overall textual salience of IMs. The EFT group (M=19.61; SD=12.42) exhibited a marginally significantly higher overall textual salience of IMs, than the CCT group (M=8.49; SD=5.12), $t(10)=-2.03$, $p=.08$, effect size, $d=1.17$.

A multivariate analysis of variance was computed to test for differences between groups in the textual salience of the different types of IMs. A marginally significant multivariate difference between the two therapeutic groups was found, Wilks's $\lambda=.56$, $F(5, 6)=.93$ $p=.52$, effect size, Partial $\eta^2=.85$. The EFT group presented a significantly higher textual salience of protest IMs, $F(1, 10)=5.88$ $p=.04$, effect size, Partial $\eta^2=.37$ (Table III - 2).

Table III – 2. Textual salience of Different Types of Innovative Moments.

	EFT group (n=6) Mean (*SD*)	**CCT group (n=6) Mean (*SD*)**	***F*(1,10)**	Partial η^2
Action	**.41(.16)**	**.45 (.29)**	**.08**	**.01**
Reflection	**7.59 (3.96)**	**5.33 (2.81)**	**1.29**	**.11**
Protest	**5.52 (4.79)**	**.72 (.74)**	**5.87***	**.37**
Re-conceptualization	**5.23 (5.48)**	**1.30 (1.51)**	**2.86**	**.22**
Performing change	**.53 (.75)**	**.86 (1.10)**	**.37**	**.04**

*p< .05.

5.3.2. Differences between EFT and CCT's outcome groups. A series of Mann-Whitney *U* tests were performed to test for differences between the two therapeutic models in good and poor outcome groups' IMs textual salience (i.e., good outcome group EFT x good outcome group CCT and poor outcome group EFT x poor outcome CCT). No significant differences emerged, supporting the idea that, despite the differences between therapeutic modalities, the process of narrative change in psychotherapy could be similar.

6. DISCUSSION

Firstly, this study confirms the applicability of the IMCS to CCT, given the emergence of IMs in this sample and the high inter-rater agreement. This means that the IMCS is a suitable tool to code and analyze CCT sessions, akin to what was found with NT (Matos, et al., 2009) and EFT (Mendes, et al., in press).

These results offer additional support to the heuristic model of narrative change and suggest that this model might in fact describe a common path of change in brief psychotherapy. Evidently, other models need to be studied; but so far the similar pattern of results obtained in NT, EFT and CCT, suggests that this might be a common pattern of novelties' development in brief therapy. Thus, as predicted, in CCT the good outcome group presents a significantly higher textual salience of re-conceptualization and performing change IMs than the poor outcome group, reinforcing the findings from previous studies (Matos et al., 2009; Mendes, et al., in press), which suggest that these IMs might be central in therapeutic change. Also, as in other therapeutic samples (Matos et al., 2009; Gonçalves et al., 2009; Mendes, et al., in press; Ribeiro, et al., 2009), re-conceptualization and performing presents an increasing tendency until the end of the therapeutic process, revealing that significant change is taking place.

The comparison between therapies (CCT and EFT) revealed that EFT produced more IMs (although the difference is only marginally significant). Insofar as the textual salience of the different types of IMs was similar across therapies, was protest the only exception, the overall sample differences primarily reflected different distributions of protest IMs, particularly a significantly greater salience of this type in EFT.

The higher production of IMs in EFT could be associated with a more process-directive stance by the therapist (Greenberg, et al., 1993; Elliott, et al., 2004). Furthermore, a previous study suggests that protest IMs emerge mainly in the context of

two-chair and empty-chair dialogues (Mendes, Ribeiro, Angus, Greenberg, Sousa, & Gonçalves, 2010). This might explain why protest IMs appear with higher textual salience in EFT. However, some caution is needed in interpreting these findings, given that the comparison between the subsamples (good and poor outcome) of EFT and CCT does not show any significant differences between the therapies. This suggests that, despite the differences in protest in the overall sample described above, the pattern of IMs in good and poor outcome is similar across therapies.

An important implication of this study for psychotherapy research in general is the finding that although therapists proceed in different ways, congruent with the therapeutic manual (Greenberg & Watson, 1998), the differences found in the IMs development does not compromise the heuristic model of change. This could mean that besides some minor differences (e.g., more overall protest in EFT), the pattern of narrative change can be the same. Interestingly, this could be another support to the proposal that common factors in psychotherapy could be much more important than the specific ones (see Norcross & Goldfried, 2005; Wampold, 2001).

The greatest limitation of this study refers to the small size of the sample, although the replication of the previous findings allows us to have some confidence in these results.

7. REFERENCES

Angus, L., & McLeod, J. (Eds.) (2004). *The handbook of narrative psychotherapy: Practice, theory and research*. London: Sage.

Angus, L., Levitt H., & Hardtke, K. (1999). The narrative processes coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology, 55*, 1255-1270.

Beck, A. T. (1976). *Cognitive therapy and emotional disorders.* New York International Universities Press.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Elliott, R., Watson, J. C., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: the process-experiential approach to change*. Washington, DC: American Psychological Association.

Fife-Schaw, C. (2006).Levels of measurement In G. M. Breakwell, S. Hammond, C. Fife-Schaw, & J. A. Smith (Eds), *Research methods in psychology* (3rd Ed.). London: Sage.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology, 22*, 1-23.

Gonçalves, M. M., Mendes, I., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology, 23*, 1 - 28.

Gonçalves, M. M., Ribeiro, A., Matos, M., Santos, A., & Mendes, I. (2010). The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & A. Gennaro (Eds.), *YIS: Yearbook of Idiographic Science 2009 - Volume 2*. Rome: Firera Publishing Group

Greenberg, L. S., & Angus, L. E. (1994) *How therapy works*. Social Sciences and Humanities Standard Research Grant.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process*. New York: The Guilford Press.

Greenberg, L.S.. Rice, L., & Watson, J. (1994). *Manual for client-centered therapy*. Unpublished manuscript. York University, Toronto.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client–centered relationship conditions and process interventions. *Psychotherapy Research, 8,* 210–224.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-Focused Therapy for Depression*. Washington: American Psychological Association.

Knox, S., Hill, C. E., Hess, S. A., & Crook-Lyon, R. E. (2008). Case studies of the attainment of insight in dream sessions: replication and extension. *Psychotherapy Research, 18,* 200-215.

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert, (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behaviour change (5th Ed.)* (pp. 84 - 135). New York: John Wiley & Sons, Inc.

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.

Mahoney, M. (1991). *Human change processes: The scientific foundations of psychotherapy.* New York: Basic Books.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19*, 68-80.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., Gonçalves, M. (in press). *Narrative Change in Emotion-Focused Therapy: How is change constructed*

through the lens of the Innovative Moments Coding System? Psychotherapy Research.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M., (2010). *Narrating Innovative Moments in Emotion-Focused Psychotherapy: A study on the developmental processes in the construction of a new self-narrative.* Manuscript in preparation.

Norcross, J. C. & Goldfried, M. R. (2005). *Handbook of psychotherapy integration*. New York: Oxford University Press.

Ribeiro, A. P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de mudança em psicoterapia: Estudo de um caso de sucesso de terapia construtivista [Narrative processes of change in psychotherapy: A good outcome case of constructivist therapy]. *Psychologica, 50*, 181-203.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1975). Empathic: an unappreciated way of being. *The counselling Psychologist, 5* (2), 2-11.

Santos, A., Gonçalves, M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82*, 449-466.

Santos, A., Gonçalves, M.M., & Matos, M. (2010). Innovative Moments and Poor outcome in Narrative Therapy. Counselling and Psychotherapy Research. DOI: 10.1080/14733140903398153

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. NJ: Lawrence Erlbaum.

White, M. (2007). *Maps of narrative practice*. New York: Norton.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

CHAPTER IV

NARRATING INNOVATIVE MOMENTS IN EMOTION-FOCUSED PSYCHOTHERAPY: A STUDY ON THE DEVELOPMENTAL PROCESSES IN THE CONSTRUCTION OF A NEW SELF-NARRATIVE

CHAPTER IV

NARRATING INNOVATIVE MOMENTS IN EMOTION-FOCUSED PSYCHOTHERAPY: A STUDY ON THE DEVELOPMENTAL PROCESSES IN THE CONSTRUCTION OF A NEW SELF-NARRATIVE[4]

1. ABSTRACT

Innovative moments (IMs) are exceptions to a client's problematic self-narrative in the therapeutic dialogue. The innovative moments coding system is a tool which tracks 5 different types of IMs – action, reflection, protest, re-conceptualization and performing change. An in-depth qualitative analysis of six therapeutic cases of emotion-focused therapy (EFT) investigated the role of two of the most common IMs – reflection and protest - in both good and poor outcome cases. Through this analysis two subtypes (I and II) of reflection and protest IMs were identified, reflecting clearly different developmental levels. Subtype II of both reflection and protest IMs are significantly higher in the good outcome group, while subtype I of both IMs types does not present statistically significant differences between groups. The evolution from subtype I to subtype II across the therapeutic process seems to reflect a relevant developmental progression in the change process.

2. INTRODUCTION

According to a narrative framework, individuals are seen as storytellers, forging their identity through the stories they tell about themselves, the others and the world (Angus & McLeod, 2004; Bruner, 1986; Polkinghorne, 1988; McAdams, 1993; Sarbin, 1986; White & Epston, 1990). The transformation of a problematic self-narrative

[4] This work was submitted to the journal *Psychotherapy Research*, in co-authorship with Inês Mendes, Antonio P. Ribeiro, Lynne E. Angus, Leslie S. Greenberg, Inês Sousa and Miguel M. Gonçalves.

construed as a set of rules of acting, feeling and thinking which are maladaptive, is made possible by the integration of new events in clients' self-narrative and also by a revaluation of the former ones. Either way novelties emerge, understood as different ways of acting, thinking or feeling. We call these novel occurrences innovative moments (or IMs, also designated in previous publications as i-moments; Gonçalves, Matos, & Santos, 2009; Gonçalves, Santos, et al., 2010). IMs entail something divergent from the problematic self-narrative which is being experienced or elaborated by the clients. For instance, if a problematic self-narrative is characterized by lack of assertiveness or difficulty expressing own feelings, then exceptions to this rule such as expressing one's needs and rights would be identified as IMs . Thus, IMs represent new pathways of thinking, feeling and acting in peoples' lives that, when expanded, could lead to the construction of a new self-narrative. Recent studies (quantitative and qualitative) have shown that change in psychotherapy can be described by the emergence of innovative moments (Matos, Santos, Gonçalves, & Martins, 2009; Ribeiro, Gonçalves, & Ribeiro, 2009; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Gonçalves, Mendes, Cruz, Ribeiro, Angus, & Greenberg, 2010; Mendes, Ribeiro, Angus, Greenberg, Sousa, & Gonçalves, in press; Santos, Gonçalves, & Matos, 2010; Santos, Gonçalves, Matos, & Salvatore, 2009).

These studies have been using the Innovative Moments Coding System (Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010) to track five different types of IMs in the therapeutic conversation (see Table IV - 1):

1. *Action* IMs are new accomplishments, specific actions which are different from what the problem impels the person to do.

2. *Reflection* IMs refer to new ways of thinking and new understandings about the implications of the problem in the clients' life which allow them to defy the demands of the problematic story.

3. *Protest* IMs entail new behaviors (like action IMs) and/or thoughts (like reflection IMs) against the problem representing a refusal of its assumptions. It is this active refusal that allows distinguishing protest from action and reflection IMs.

4. *Re-conceptualization* IMs are a more complex and multifaceted type of IMs which enables the clients' comprehension about what is different in themselves and the process that fostered this transformation. These IMs require the elaboration of three components: the self in the past (problematic self-narrative), the self in present (the emergent new self-narrative) and the depiction of the process that allowed for this change.

5. *Performing Change* IMs represent the performance of change, new ways of acting and being which emerge from the occurrence of the change process. They represent a process of transforming in-therapy outcomes into extra-therapy changes.

Table IV – 1. IMs with examples. From *The Innovative Moments Coding System: A coding procedure for tracking changes in psychotherapy*, by M. M. Gonçalves, A. P. Ribeiro et al., 2010. Adapted with permission.

	Contents	**Examples (Problematic narrative: depression)**
Action	• New coping behaviors facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control ; • Searching for information about the problem(s).	C: Yesterday, I went to the cinema for the first time in months!

Reflection	***Creating distance from the problem(s)*** • Comprehension – Reconsidering problem(s)' causes and/or awareness of its effects; • New problem(s) formulations; • Adaptive self instructions and thoughts; • Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being. ***Centered on the change*** • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies; implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	C: I realize that what I was doing was just, not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go… C: I believe that our talks, our sessions, have proven fruitful, I felt like going back a bit to old times, it was good, I felt good, I felt it was worth it.
Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s). ***Emergence of new positions*** • Positions of assertiveness and empowerment;	C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!? C: I am an adult and I am responsible for my life, and, and, I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.
Re-conceptualization	RC always involve two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs… T: How did you have this idea of going to the museum? C: I called my dad and told him: we're going out today! T: This is new, isn't it? C: Yes, it's like I tell you… I sense that I'm different…

Performing Change	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource to new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	T: You seem to have so many projects for the future now! C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.

Several studies using this methodological tool were developed to analyze psychotherapy change, corroborating its applicability to diverse therapeutic modalities. Hypothesis-testing studies in narrative therapy (NT; Matos et al., 2009), in emotion-focused therapy (EFT; Mendes et al., in press) and in client-centred therapy (CCT; Gonçalves, Mendes, et al., 2010) have shown that IMs reveal a significantly higher presence in good outcome cases than in poor outcome cases. This difference between good and poor outcome cases is mainly due to differences in two types of IMs: re-conceptualization and performing change. Thus, action, reflection and protest IMs have a similar magnitude in poor and good outcome cases, contrarily to re-conceptualization and performing change IMs. Moreover re-conceptualization and performing change IMs, in good outcome cases, display an increasing trend from middle therapy until termination and at the end of therapy re-conceptualization IMs is the most dominant type in the therapeutic conversation. Re-conceptualization and performing change IMs are usually absent or have a much reduced expression in poor outcome cases. These two types seem to be vital in the reconstruction of a new self-narrative and in successful therapeutic change.

From these studies with IMCS a heuristic model of change in successful brief therapy was developed (Gonçalves et al., 2009; Matos et al., 2009). Here, we present a

summary of this model. In the first stage of therapy, action and reflection IMs are the first ones to appear and they constitute the first signs that something new is emerging in the client's life, representing new ways of acting and new understandings. Protest IMs appear after the first cycles of action and reflection or, in other cases, they emerge alongside with them early on in therapy. This IM type embodies a refusal of the assumptions of the problematic narrative, representing a strong attitudinal movement against the problem that has been ruling the client's life. This movement of refusal of the problematic narrative enables the repositioning of the self in a more proactive and agentic stance in therapy and in life. Re-conceptualization IMs frequently emerge in the middle stage of therapy after several sequences of action, reflection and protest IMs. This more complex IM entails a meta-position through which the client is able to articulate the former problematic self-narrative with the new emerging one (e.g., *before I was more timid and now I'm more outgoing, an extrovert person*) and has access to the change process from one position to the other (e.g., *dealing with some of the hurts, bringing them out here and put them where they belong in, allow this change to occur*).

Action, reflection and protest although representing meaningful novelties in the client's life, seem to be insufficient for a sustainable change to emerge. Re-conceptualization is crucial in the construction of a new self-narrative probably for two related reasons. First, it grants narrative coherence to the more episodic action, reflection and protest IMs through the articulation of the past with the present. Through this articulation a sense of continuity is achieved. Second, it allows the client's repositioning as the author of his or her own self-narrative while describing the change process from past to the present self. When elaborating a re-conceptualization IM the client is no longer the actor of the problematic self-narrative but is rather authoring a transformation process in the path of his or her preferable living self-narrative. After

some elaboration of re-conceptualization IMs new cycles of novelties exploration occur again in the form of action, reflection and protest IMs that are congruent with the previous re-conceptualization IMs. In turn, these occurrences further validate re-conceptualization IMs: as clients narrates themselves differently than before (re-conceptualization IMs), new actions, thought and feelings congruent with this narration occur, further supporting the narrated changes. Performing change IMs are projections into the future of this new position which allows for the new self-narrative to have a future (see Figure IV - 1).

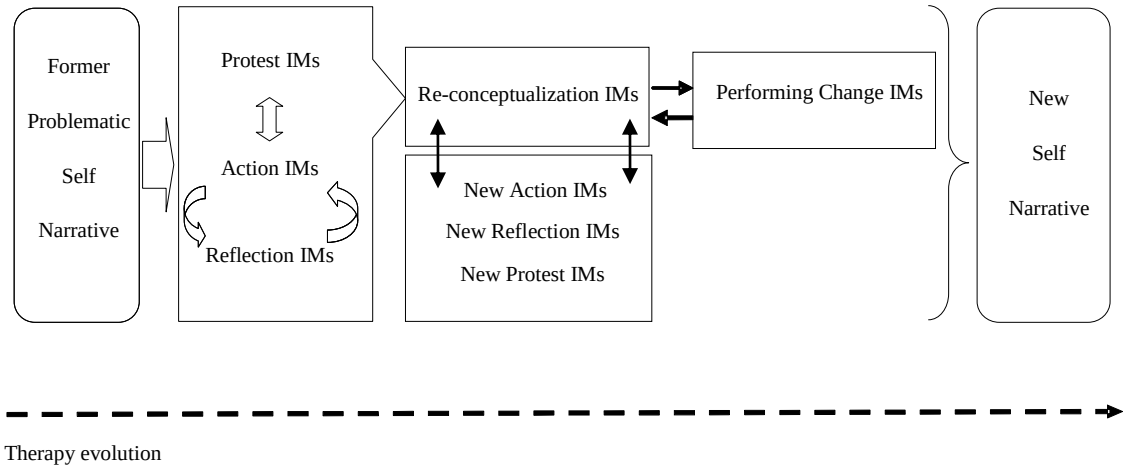

Figure IV - 1. Heuristic model of good outcome cases drawn from Narrative Therapy.

Research regarding IMs in clinical samples (NT; Matos, et al., 2009; EFT; Mendes et al., in press; CCT; Gonçalves, Mendes, et al., 2010) has focused on the differences between groups, highlighting the role of re-conceptualization and performing change IMs in the construction of psychotherapeutic change. These studies have overlooked the role of action, reflection and protest IMs in the process of change since they don't reveal significant differences between outcome groups. However, although action IMs are in

some samples relatively rare, as in EFT (Mendes et al., in press), reflection and protest are very common in several modalities of therapy (Gonçalves, Santos, et al., 2010; Matos et al., 2009) and they precede the elaboration of re-conceptualization in good outcome cases. They are the most common IMs all along the therapeutic process in poor outcome cases and the most common in the initial and middle phase of therapy in good outcome cases.

In this study we intend precisely to shed some light in the role of these IMs in the change process. Thus, this study main target is to study how reflection and protest IMs evolve in good and poor psychotherapy outcomes, also trying to understand how they contribute to the process of change. One way to study this problem is to inquire if, despite the absence of differences on a quantitative level between good and poor outcome cases on reflection and protest IMs, there are any differences on a more qualitative level.

3. REFLECTION AND PROTEST IMS

In a previous single-case study with the IMCS in the well-known and intensively studied case of Lisa (Gonçalves, Mendes, et al., 2010; Honos-Webb, Stiles, Greenberg & Goldman, 1998; "The Case of Lisa", 2008) two different types of reflection and protest IMs emerged throughout the therapeutic process. We depart from what we have found in this case to test if the same applies to other cases of EFT. In this case, reflection IMs evolve throughout therapy from (1) new understandings about the problem and its causes to (2) strategies to deal with the problem and new self-positions. We termed the former type of reflection *subtype 1* and the later *subtype 2*, highlighting that these subtypes clearly involve different meanings and seemly different types of novelties, present in different phases of the changing process.

A similar differentiation and evolution was visible in protest IMs: Lisa evolves from a problem-oriented position (protest subtype I), in which she is focused in criticizing the problem; to the emergence of new self-positions, in which she asserts her rights and wishes (protest subtype II) (Gonçalves, Mendes, et al., 2010). To further illustrate these differences we present the subtypes – I and II – of both reflection and protest IMs followed by a clinical vignette from Lisa's case (Gonçalves, Mendes, et al., 2010), with depression as the problematic self-narrative.

Reflection IM subtype I – Creating distance from the problem

This IM subtype involves new formulations and comprehensions about the problem, new understandings about the problem's causes and effects in client's life and intentions to defy it.

Clinical Vignette

Therapist: *so it's sort of - like you don't - you don't really trust him (husband) anymore?*

Client: *I don't, I have no trust for him, this is why maybe I've come to a point where I have said okay, I'm not going to continue banging my head against the wall it's tiring and it's so much; you know - I consume my energy. (...) and it just feels like I have to do something now*

Therapist: *so it's getting… it's just feeling pretty bad right now is what you're saying right?*

Client: *it's like I don't want to go another day without doing something (crying).* (4th Session – new comprehension about the problem)

Reflection IM subtype II – Centered on Change

This subtype considers the client's elaboration about the therapeutic process, the strategies that he or she implemented in order to achieve therapeutic goals towards

change, statements of the difference between a past and a present self-position and feelings of well-being that come along with the awareness of these changes.

Clinical Vignette

Client: *(crying) I want to um grow and um, experience what I have to offer and um, um, just to learn about what's out there.*

Therapist: *mm-hm. what's happening when you say that?*

Client: *yeah, I'm positive about it.* (...) *I feel positive and strong.*

Therapist: *mm-hm.*

Client: *it's okay to ask for these things [acceptance for who she is and what she feels]*.

Therapist: *you feel okay about it?*

Client: *yeah, yeah, it's a- it's a part of me, so I'm not going to um, turn it down.* (12th Session – elaborating about her change process)

Protest IM subtype I – Problem oriented positions

Protest subtype I enables the self-disclosure of the negative affect that the problem brought into the client's life. This subtype entails a confrontational position in which the client criticizes the problem's assumptions and the persons that may be supporting them. Client discourse is centered on others and focuses on criticizing the ones he or she feels hurt or neglected by.

Clinical Vignette (during an empty chair dialogue with client's father assuming a position of critique)

Client: *yeah, I resented to pretend living that way, it really makes me angry.*

Therapist: *tell him about that anger. It really makes you angry.*

Client: *um, it wasn't fair to be brought up that way. I think you're very selfish!*

Therapist: *say that again.*

Client: *I think you're very selfish!*

Therapist: *what do, what do you feel as you say that, there's some real power in that, the way that you say that.*

Client: *just thought about yourself, and you only took the good things and not the bad, um, - - - - uh, only thought about yourself and not me or my brothers or mom.*

Therapist: *so was it like, I want you, I wanted you to think about me.*

Client: *yes, and you only thought about me when you thought it was important to you and only what, what you wanted at that time.* (3rd Session)

Protest IM subtype II – Emergence of new self-positions

Correspond to a position of assertiveness in which the client repositions him or herself in relation to the problem. Client assumes a different stand centering the discourse in the self and on the self assertion of his or her needs, enabling the client to feel that he or she does matter and that caring about oneself is an important priority. This creates a feeling of entitlement of own needs and rights building a sense of personal agency that will foster positions of self-empowerment and strength.

Clinical vignette

Therapist: *Mm-hm. So what do you feel towards him right now?*

Client*: I feel bigger and - and taller and - - I feel that I can - stand up for myself.*

Therapist*: Mm-hm - what happens when you say that - I feel I can stand up for myself - - you can just - get up and - walk out - tell, wanted to*

Client*: Because um I'm an adult and - I can make my own decisions ... I deserve to feel what I feel and - ah what I - want to do and is right for me and my kids – I'm going to stand up for myself - um - I deserve that - I'm a good person and I'm not going to let you step on me anymore.* (5th Session - Empty-chair dialogue with client's husband –

self-empowerment).

This differentiation between subtypes suggests that type I -- in both reflection and protest IMs -- is clearly less developed than subtype II, in terms of the therapeutic change progress. Notice that in reflection IMs it is the difference between the comprehension of the problem and the reflection about change that allows differentiating subtypes. If we apply the transtheoretical model of change from Prochaska and Norcross (2001) to this difference one could say that reflection subtype I probably represents IMs situated in the contemplation stage, and reflection subtype II are probably taking place in later stages, like preparation or action.

The differentiation of protest subtype I and II also reflect very different processes. In the first, the person is rejecting the problem or its assumptions, mainly centering himself or herself on others, in the subtype II he or she is centering on his or her self-needs. Although the stage model from Prochaska and Norcross (2001) does not apply so linearly as in reflection IMs, it is highly probable that again subtype I reflects contemplation stage and subtype II reflects later stages.

The assimilation model from Stiles (2006) could further help us understand the differences between subtype I and II of reflection and protest IMs. The assimilation of problematic experiences perspective conceptualizes people as made of multiple internal voices, and suggests that the progress in therapy is associated with the integration of voices – the voice of an unwanted problematic experience in a dominant community of voices (Honos-Webb & Stiles, 1998; Osatuke & Stiles, 2006). The sequence through which this integration is achieved is formulated in the eight stages of the Assimilation of Problematic Experiences Scale (APES). According to this model, we would identify reflection and protest IMs subtype I with a level 2 (vague awareness/emergence - the client begins to be more aware of the non-dominant voice) in the APES scale. We may

also consider that sometimes reflection subtype I may achieve level 3 (problem statement/clarification - the client is able to have a clear statement of the problem), specifically when clients elaborate new formulations about the problem and are able to articulate the consequences of it in his or her life. Subtype II of both reflection and protest IMs are related to stages 4 (understanding/insight) and 5 (application/working through) since they entail clients' movement through a clear understanding of the problematic experience with mixed affect to a positive affect and problem solving efforts. In sum, subtypes I are probably less developed (contemplation in the transtheoretical model of behavior change or stage 2 or 3 in APES), then subtypes II (preparation and higher in the transtheorethical model or stage 4 and higher in APES).

4. PRESENT STUDY

Departing from this single-case study we formulate the following research questions for the present study:

1. Are reflections and protest IMs subtypes present and reliably identified in the other EFT cases, besides the case of Lisa?
2. Are any of the subtypes more characteristic of poor or good outcome cases?
3. What are the developmental patterns of these subtypes throughout therapy, in good and poor outcome cases?

As the model of change previously presented suggests, reflection and protest IMs are signs that change is taking place, to the client and to significant others. Thus, these IMs are precursors of re-conceptualization in good outcome cases. Contrarily, in poor outcome cases it seems that the clients are unable to construct other types of novelties besides these ones. Somehow they are stuck in reflection and protest IMs (sometimes also in action IMs), without being able to construct re-conceptualization and performing

change IMs. Thus, studying how reflection and protest IMs evolve and how their subtypes develop in good and poor outcome cases will certainly add a refinement to the model of change previously presented.

5. METHOD

5.1. Clients

Clients were part of the York I Depression Study (Greenberg & Watson, 1998), a project designed to assess treatments of major depression comparing 17 process-experiential (PE; also referred as EFT) and 17 Client-Centered Therapy (CCT). In this study the clients were randomly assigned to one of the two different treatments (EFT or CCT). We studied 6 out of 17 cases assigned to EFT, which had 15 to 20 sessions of individual psychotherapy once a week. These 6 cases were the ones with complete transcripts and data set for intensive process analyses.

Of the six clients in this sample, four were women and two were men (age range = 27-63 years, *M* = 45.50 years, *SD* = 13.78). Clients completed an average of 17.50 (*SD* = 1.87) sessions. Five of the clients were married and one was divorced. All the clients were Caucasian.

Clients were classified as having good or poor outcomes based on the analysis of the *Beck Depression Inventory* (BDI; Beck, Steer, & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) pre- to post-test change scores. BDI is a well-known 21 item self-report instrument to assess symptoms of depression.

A Reliable Change Index (RCI) analysis of BDI pre- to post-test change scores classified three clients as having met criteria for recovered (i.e., passed both a BDI cut-off score of 11.08 and RCI criteria) and the other three clients were classified as unchanged (i.e., have not passed both BDI cut-off score of 11.08 and RCI criteria) at

treatment termination (see Jacobson & Truax, 1991; McGlinchey, Atkins, & Jacobson, 2002). More specifically, pre-post BDI scores for the good outcome cases were 25 to 3, 30 to 5, and 35 to 4, whereas for the poor outcome cases was 15 to 13, 23 to 22, and 24 to 18.

5. 2. Therapists

Five therapists conducted the therapeutic process of the six clients analyzed in this study. Four of the therapists were female and one was male. They were of varied levels of education, from advanced doctoral students in clinical psychology to PhD clinical psychologists. Four of the therapists were of Caucasian origin and one was Indian. All therapists received a 24 week training according to the manual devised for the York I Depression study (Greenberg, Rice & Elliott, 1993). The received training consisted of eight weeks of CCT, six weeks for systematic evocative unfolding, six weeks for two-chair dialogue and four weeks for empty-chair dialogue.

5.3. Treatment

Therapeutic relationship is one of the core principles of emotion-focused therapy which implies the facilitation by the therapist of a relationship based on atonement, validation, empathy, trustworthiness, providing a safe and responsive therapeutic environment. Generally, the goal in EFT is to promote emotional awareness and enhancing clients' emotional processing. Two-chair dialogue for self-evaluative and self-interruptive conflict splits, empty-chair dialogue for unfinished business with a significant other, focusing (Gendlin, 1981) at a marker of an unclear felt sense and systematic evocative unfolding for problematic reactions are the therapeutic interventions added to the client-centered relational conditions in EFT. The therapists

on the York I Depression Study followed the manual developed by Greenberg, Rice and Elliott (1993).

5.4. Procedure

5.4.1. IMs coding and reliability.

In a previous study, six EFT cases, from the York I Project on Depression Study (Greenberg & Watson, 1998), were coded according to the IMCS (Mendes et al., in press). We summarize here the procedures used in that study on IMs coding. Two coders were intensively trained on this methodological tool till they reach reliability (Cohen's Kappa higher than 75%). After the IMs' training, the two coders that were unaware of the outcome status of the cases, consensually defined the problem in order to be able to track the IMs, its type and the definition of each IMs' *salience*. To measure salience we use the temporal salience index (percentage of time of the session occupied by IM's elaboration) when we code from video or audio, and when we use transcripts, as in this study, we use the textual salience index (percentage of words of the session involved in the IM's elaboration). The sessions were coded from the transcripts of the cases.

The percentage of agreement on overall IMs salience was .89. Reliability of distinguishing IMs' types, assessed by Cohen's kappa, was .86 (based on a sample size of 1397 IMs).

5.4.2. Reflection and Protest IMs subtypes coding and reliability.

For the present study, we forward an in-depth analysis of the speech content of reflection and protest IMs from all the sessions (n=105) of the six therapeutic cases in order to understand if, despite the absence of statistical differences between groups, they are in fact qualitatively different. The data from the two outcome groups – three good

and three poor outcome cases – were intensively analyzed. Hence, 49 sessions fit into the good outcome group and 56 sessions belong to the poor outcome data set.

Therefore, 105 therapeutic sessions were reviewed in which 775 reflection IMs and 377 protest IMs were coded in terms of the subtypes found in Lisa case (Gonçalves, Mendes, et al., 2010). The coding procedure required data analysis by two raters (first and second authors), that coded 100% of reflection and protest IMs in the 105 EFT sessions.

These two raters who coded the reflection and protest IMs regarding their subtypes were the same that, in the previous study, coded all these six dyads according to the IMCS (Mendes et al., in press). So, these two raters had already a thorough knowledge of each case.

6. RESULTS

6.1. *Are reflections and protest IMs subtypes present and reliably identified in the six EFT cases?*

All reflection and protest IMs were coded according to the criteria for the subtypes referred above. 43,5% of reflection and protest were identified as subtype I and 56,5% were coded as subtype II.

As a measure of agreement on the reflection and protest IMs subtypes coding we used Cohen's Kappa, which in this sample was of .83, showing a strong agreement between judges (Hill & Lambert, 2004). Thus, like in Lisa case, reflection and protest IMs subtypes can be reliably identified.

6.2. *Are any of the subtypes more characteristic of poor or good outcome cases?*

This question was addressed by carrying out a Mann-Whitney *U* test given the number of participants in each group (n=3). Clients from the good outcome group were found to have significantly more reflection subtype II (U =-5.27, p< .001) and protest

subtype II (*U* =-5.61, p<.001) IMs than the clients from the poor outcome group, considering the overall therapeutic process. There were no significant differences between good and poor outcome groups on subtype I of both reflection (*U* = -1.37, p=.17) and protest (*U* = -1.23, p=.22) IMs (Figure IV - 2).

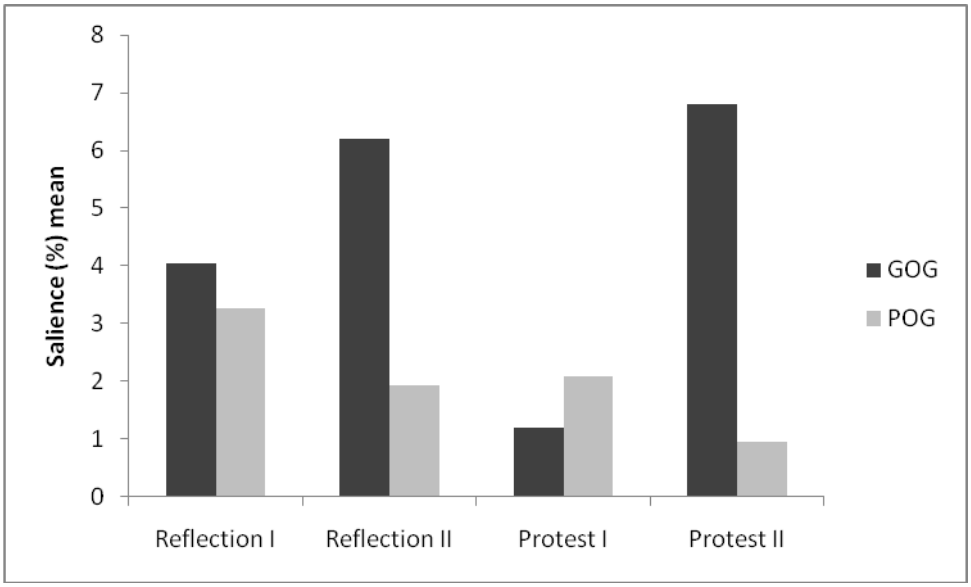

Figure IV - 2. Reflection and Protest innovative moments subtypes I and II in good and poor outcome groups.

6.3. *What is the developmental profile of these subtypes throughout therapy?*

We have considered a non-parametric smoother to summarize the trend of the response variable as a function of treatment session. The black solid line in the plot represents the non-parametric smooth spline of the observed data (Keele, 2008) with respective 95% confidence intervals, within each outcome group. The advantage of such smoother is that we do not have to impose any rigid form for such function. The non parametric smoothing spline emerges as a solution of an optimization problem, of minimizing simultaneously the residual sum of squares and second derivative of such a function (Hastie & Tibshirani, 1990).

Although both subtypes of reflection and protest IMs emerge, from the beginning of therapy, in both good and poor outcome groups, they reveal different developmental paths. Reflection IMs subtype I presents a decreasing development path which is similar in good and poor outcome groups. This trend is consistent with the absence of significant differences previously presented (Figure IV - 3). Reflection IMs subtype II demonstrates an increasing trend both in good and poor outcome group, being clearly higher in the good outcome group (Figure IV - 4), which once again is consistent with the test of differences.

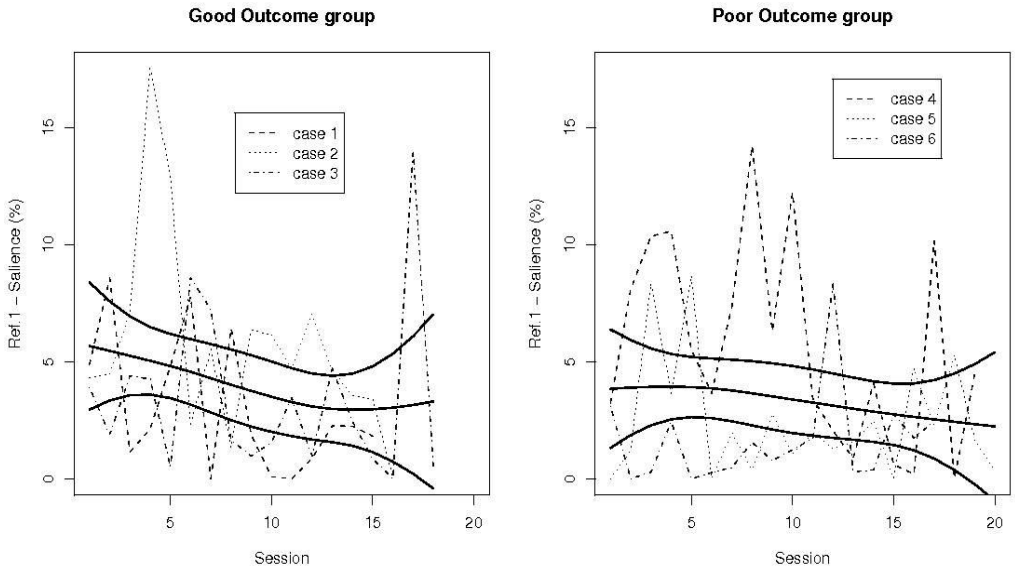

Figure IV - 3. Reflection innovative moments subtype I development throughout therapy in good and poor outcome groups.

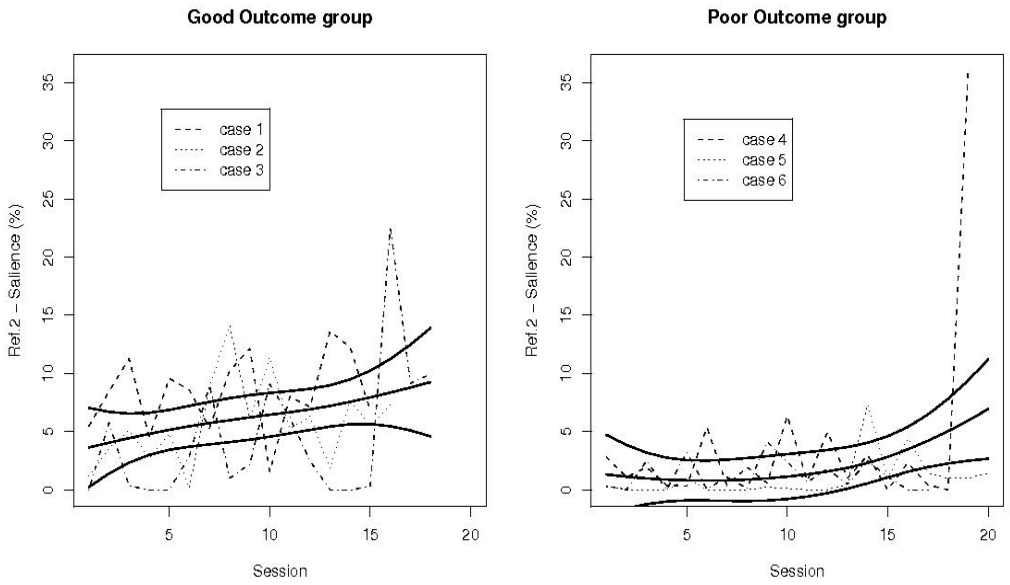

Figure IV - 4. Reflection innovative moments subtype II development throughout therapy in good and poor outcome groups.

Protest IMs subtype 1 are very similar in their development path in poor and good outcome cases, being stable along the treatment (Figure IV - 5).The same does not occur with protest IMs subtype II, exhibiting very different paths in good and poor outcome cases, a difference which is again consistent with the statistical differences between groups. This IM subtype is almost absent in the poor outcome group all along the therapeutic process whereas in the good outcome group it shows a progressive line until middle therapy decreasing towards termination (Figure IV - 6).

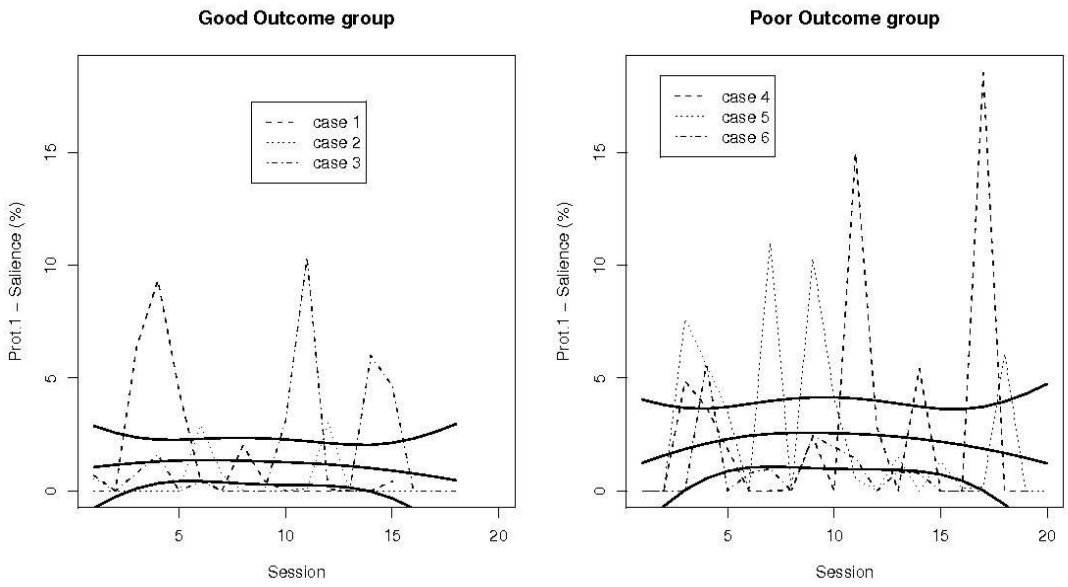

Figure IV - 5. Protest innovative moments subtypes I development throughout therapy in good and poor outcome groups.

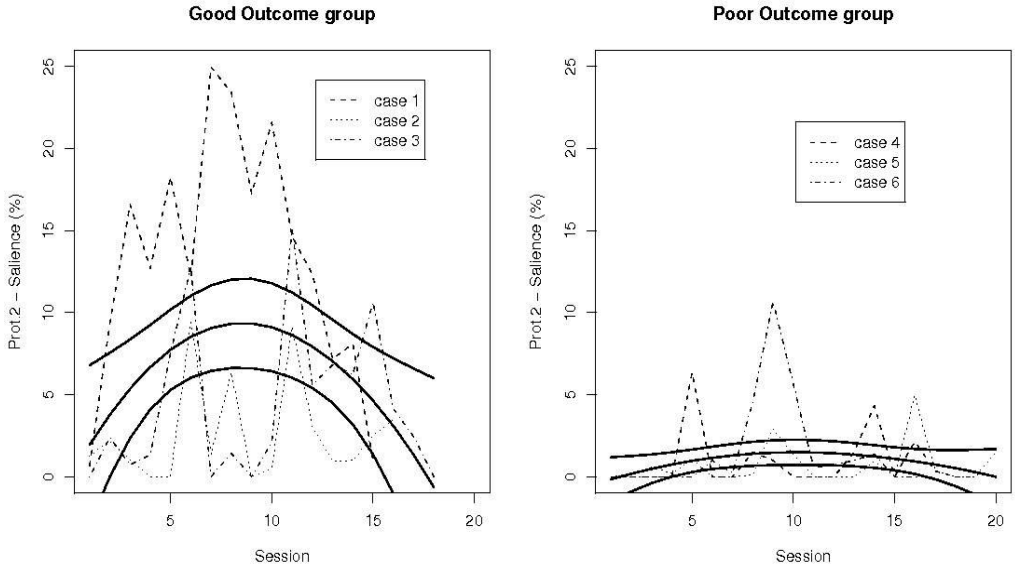

Figure IV - 6. Protest innovative moments subtypes II development throughout therapy in good and poor outcome groups.

7. DISCUSSION

These results clearly suggest that the subtypes first found in the analysis of the case of Lisa (Gonçalves, Mendes, et al., 2010) also occurred in other EFT cases, being reliably identified and coded in the transcripts. Moreover, significant differences occurred between good and poor outcome groups in both subtypes II of reflection and protest IMs, but not on subtypes I. This means that, despite the absence of quantitative differences between good and poor outcome cases on reflection and protest IMs found in previous studies in which the subtypes were not considered (Matos, et al., 2009; Mendes et al., in press), if we take these qualitative differences (the subtypes) into account clear differences emerge. Curiously, the differences between outcome groups occur only in subtypes II (higher in good outcome group), that is, in the more developed subtypes. Thus, both good and poor outcome clients seem able to elaborate reflection and protest IMs of subtype I, but good outcome cases seem to elaborate more (or more extensively) subtypes II. These results are congruent with developmental models of psychotherapy, like the transtheoretical model of behavior change (Prochaska & Norcross, 2001) and the assimilation model (Stiles, 2006). As we suggested before, subtypes I of reflection and protest IMs are probably associated with the contemplation stage of the transtheoretical model of behavior change, and with level 2 (or 3) if we consider the APES scale (Stiles, 2006). If subtypes I, which constitute first steps in the process of change, are not expanded and further elaborated, resulting in reflection and protest subtypes II, they probably do not lead toward self-transformation, as it occurs in good outcome cases. Therefore, clients need to progress into a next stage of change (e.g. preparation) or level of assimilation (e.g. level 4 – understanding/insight) to achieve a sustainable change.

The developmental trends of reflection and protest IMs subtypes I and II provided by the non parametric smooth spline allow us to have a picture of their developmental trend throughout therapy. Taking the whole sample into account, reflection IMs subtype I decreases along treatment, while subtype II increases. Subtype I is centered on understanding the problem, its consequences and effects in the client's life, helping the client to make sense of the emotional experience and the needs these emotions are expressing (Greenberg & Watson, 2006). As the client progresses in therapy, reflection subtype II increases its presence, addressing new meanings centered on change. This includes, for instance, elaboration on how change is occurring, which strategies are being implemented, emergent self-positions and new feelings when adopting this new way of experiencing the self. The increasing pattern of reflection subtype II is much more pronounced in the good outcome group than in the poor outcome one. Moreover, this difference is reinforced by the test of differences that shows that subtype II is significantly higher in good outcome cases. So, we could speculate that as reflection subtype I decreases it is substituted in good outcome cases by reflection subtype II, a more developmental differentiated subtype as we claimed above.

Protest IMs have a curious trend. Subtype I is relatively stable is both outcome groups. Subtype II is also considerably stable in poor outcome cases. The shape of good outcome cases is clearly distinct, having a U-inverted trend. Moreover, as with reflection IMs, the test of differences only finds differences in subtype II and not in subtype I. This suggests that one important difference between good and poor outcome cases is the difficulty in the last group to change from a focus on others (subtype I) to a focus on the needs of the self (subtype II). It is curious that protest subtype II has not an increasing trend all along treatment like reflection subtype II, suggesting that in good outcome cases the affirmation of one's needs, present in subtype II, decreases after the

middle of therapy. The decreasing line of protest subtype II in the middle of the treatment is coincident, in time, with the increasing line of re-conceptualization IMs in the good outcome group (Mendes et al., in press) and we hypothesize that the clients' elaboration of positions of empowerment, that are embedded in subtype II of protest IMs, may after the middle of treatment be involved in the elaboration of re-conceptualization. The new self-positions which emerge in the form of protest IMs subtype II may serve as scaffolding for the development of new views of self or re-conceptualization IMs.

These results are also congruent with the assumptions of EFT, which obviously make us wonder if these results will be replicated in other models of therapy, representing transtheoretical processes of change. Therapeutic interventions like two-chair and empty-chair dialogues, demonstrate a shift of core client themes into new and more differentiated understandings of their problems and their view of their own self. As Greenberg (2002) pointed out, the evocation and exploration of the personal meaning of these emotional experiences are related to constructive change in psychotherapy. In EFT through the therapeutic chair work clients are stimulated to give voice to another position that involves the voice of their self needs and rights. In good outcome cases, this position of entitlement and empowerment is elaborated in the form of reflection and protest subtypes II and most likely later integrated in re-conceptualization IMs. In poor outcome cases clients seem to stay stuck (subtype I), probably as they resist to deeply experience their emotions not allowing the voice of the experiencing self to stand up for itself (subtypes II). This maintenance of the emotional distressing experience constitutes an impediment to progress in therapy. When stuck, clients can not develop the emotional awareness and the "reflective awareness or meta-cognition [that] is a fundamental skill required for successful psychotherapy"

(Greenberg & Watson, 2006, p.83). Moreover, Greenberg, Auszra and Herrmann (2007) suggest that clients also need to take responsibility for their emotional experience instead of blaming others for it (protest subtype I) and assuming this responsibility facilitates the view of themselves as agents of their own self-change process (subtypes II of reflection and protest IMs).

To sum up, these results seem congruent with EFT theory (Greenberg & Watson, 2006) and some developmental models of therapy (Prochaska & Norcross, 2001; Stiles, 2006), that conceive therapy as a process of increasing complexity of the process of self-change. At this point it is not clear if these patterns are exclusive to EFT samples or they reflect common processes of change present in several models of brief psychotherapy, similarly to other findings that resulted from the application of IMCS (Gonçalves, Santos, et al., 2010).

The size of the analyzed sample of the present study makes its conclusions limited and exploratory. Another limitation was the knowledge that coders had about the status of the cases, in terms of good or poor outcome, since they were the ones doing the previous coding with the IMs in the study of Mendes and colleagues (in press).

Although this study helped furthered the development of the IMCS, allowing us to understand the role of two of the most common IMs – reflection and protest -, we can only consider these new findings in the light of the specific therapeutic model in which they emerge – EFT. More research is needed to see if the same subtypes emerge in other forms of therapy and if they have the same role in the construction of a preferred self-narrative.

8. REFERENCES

Angus, L., & McLeod, J. (Eds.) (2004). *The handbook of narrative psychotherapy: Practice, theory and research*. London: Sage.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

Gendlin, E. T. (1981). *Focusing* (2nd ed). New York: Bantam Books.

Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology, 22*, 1–23.

Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Narrative change in client-centered therapy and emotion-focused therapy: A comparative study. Manuscript in preparation.

Gonçalves, M. M., Mendes, I., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology, 23*, 1 - 28.

Gonçalves, M. M., Ribeiro, A., Matos, M., Santos, A., & Mendes, I. (2010). The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & A. Gennaro (Eds.), *YIS: Yearbook of Idiographic Science 2009 - Volume 2*. Rome: Firera Publishing Group.

Gonçalves, M. M., Santos, A., Matos, M., Salgado, J., Mendes, I., Ribeiro, A., Cunha, C. & Gonçalves, J. (2010). Innovations in psychotherapy: Tracking the narrative construction of change. In J. D. Raskin, S. K. Bridges, & R. Neimeyer (Eds.), *Studies in meaning 4: Constructivist Perspectives on Theory, Practice, and Social Justice* (pp. 29 - 64). New York: Pace University Press.

Greenberg, L. S. (2002). Emotion-focused therapy: Coaching clients to work through their feelings. Washington, DC: American Psychological Association.

Greenberg, L. S., Auszra, L., & Herrmann, I. R. (2007). The relationship among emotional productivity, emotional arousal and outcome in experiential therapy of depression. *Psychotherapy Research, 17*, 482–493.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process*. New York: The Guilford Press.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client–centred relationship conditions and process interventions. *Psychotherapy Research, 8*, 210–224.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-Focused Therapy for Depression*. Washington: American Psychological Association.

Hastie, T. & Tibshirani, R. (1990). *Generalized additive models, Volume 43 of Monographs on statistics and applied probability*. London: Chapman & Hall.

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in terms of voices. *Psychotherapy Research, 7*, 23–33.

Honos-Webb, L., Stiles, W. B., Greenberg, L. S., & Goldman, R. (1998). Assimilation analysis of Process-Experiential Psychotherapy: A comparison of two cases. *Psychotherapy Research, 8,* 264-286.

Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.

Keele, L. (2008). *Semiparametric regression for the social sciences*. New York: John Wiley and Sons.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19*, 68-80.

McGlinchey, J.B., Atkins, D.C., & Jacobson, N.S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy, 33*, 529–550.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M. (in press). *Narrative Change in Emotion-Focused Therapy: How is change constructed through the lens of the Innovative Moments Coding System?* Psychotherapy Research.

Osatuke, K., & Stiles, W. (2006). Problematic internal voices in clients with borderline features: An elaboration of the assimilation model. *Journal of Constructivist Psychology, 19*, 287–319.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.

Prochaska, J. O. & Norcross, J. (2001). Stages of change. *Psychotherapy, 38,* 443-448.

Ribeiro, A.P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de mudança em psicoterapia: Estudo de um caso de sucesso de terapia constructivista [Narrative change processes in psychotherapy: A case-study of successful

constructivist therapy]. *Psychologica, 50, 181-203.*

Santos, A., Gonçalves, M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 82,* 449-466.

Santos, A., Gonçalves, M.M., & Matos, M. (2010). Innovative Moments and Poor-outcome in Narrative Therapy. Counselling and Psychotherapy Research. DOI: 10.1080/14733140903398153

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Stiles, W. B. (2006). Assimilation and the process outcome: Introduction to a special issue. *Psychotherapy Research, 16,* 389–392.

The Case of Lisa [Special Section] (2008). *Psychotherapy Research, 18* (6).

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: Norton.

CONCLUSION

CONCLUSION

Research in the field of psychotherapy has been continually growing, gathering, over the years, more pluralistic research methods to help us understand how psychotherapy works (Lutz & Hill, 2009). This question has been one of the central questions in this field (Drozd & Goldfried, 1996; Greenberg, 1986; Lambert, 2004; Rice & Greenberg, 1984; Stiles, Shapiro, & Elliott, 1986). In 1986, Greenberg proposed the need of research on change processes to better understand how psychotherapy works, referring, namely, to the study of "clinically meaningful events" (p.4). Recently, Elliott (2010) presented a complex research paradigm, named *significant events approach* that gathers elements from three basic genres of change process research. This approach presents "an interpretive, theory-building framework" (p. 129) combining 1) the identification of important therapeutic moments; 2) the development of qualitative sequential description of what happened across sessions and/or cases; and 3) making the link between in-session processes to post-therapy outcomes. I believe that the present dissertation reveals an effort in the direction of the significant events research paradigm (Elliott, 2010) since it involve the use of a coding system to track important moments in therapy across sessions in several therapeutic cases taking into account the outcome status of the case.

The findings displayed through this dissertation allowed us to further the development of a conceptual framework that synthesizes the process of narrative change in successful brief psychotherapy. One of the first and most relevant results concerns the applicability of the Innovative Moments Coding System (IMCS) to other therapeutic models – emotion-focused therapy (EFT) and client-centered therapy (CCT) –, and to a different problematic – depression. This is an important finding since the IMCS was

elaborated in the context of narrative therapy (NT) underlying its assumptions. The IMCS tracks narrative novelties in the therapeutic conversations which can be something easy to assume that would happen in cases of NT since the therapist is actively searching for unique outcomes (or innovative moments) to facilitate re-authoring conversations and a new self-narrative. With the first study, the single case-study, we found that this coding system could be applied in a distinct therapeutic model. The following studies also had as one of major purposes the applicability of the IMCS, specifically to samples of EFT and of CCT giving more empirical evidence to the IMCS as a reliable methodological tool for the study of narrative changes in the client's discourse during therapeutic sessions. Other studies were developed in our research team giving additional support to this finding, for example the applicability of the IMCS to constructivist therapy focused on implicative dilemmas (Ribeiro, Gonçalves, & Ribeiro, 2009) and constructivist therapy with complicated grief (Alves, Mendes, Neimeyer, & Gonçalves, 2010).

The other major finding regards the validation of the model of narrative change that was hypothesized in the pioneering study with the 10 clinical cases followed with NT (Matos et al., 2009). One of the limitations of this first study contemplates the fact that the IMCS was developed within the narrative approach. In this dissertation the authors stressed the need of the analysis of other therapeutic models and other therapeutic populations to endorse the model of narrative change developed upon the findings of study of Matos and collaborators (2009). The three first studies of this dissertation were conducted in order to address this need. The analysis of the IMs in the single EFT case-study, in the 6 EFT dyads and in the 6 CCT dyads undergoing treatment for depression, allowed us to give more evidence to the proposed model of narrative change. The results of these analyses replicate the results found with NT providing additional

support to the model of narrative change. In all the studied therapeutic approaches NT, EFT, CCT, the good outcome group presents higher salience of IMs when compared to the poor outcome group. This result leads us to hypothesize that the narrative elaboration of IMs is related to therapeutic change. Action, reflection and protest IMs do not present statistical differences between groups. Only re-conceptualization and performing change IMs present statistical differences between groups being these two types higher in the good outcome group. It is important to point out that performing change is absent in the poor outcome group of EFT and emerge sparsely in NT and CCT. The poor outcome cases are characterized by only action, reflection and protest IMs, throughout the process, with an almost total absence of re-conceptualization and performing change IMs. The good outcome group is characterized by a higher salience of IMs throughout the therapeutic process and higher diversity of the IM types. Action, reflection and protest IMs are more specific of the initial and middle phases of therapy displaying higher salience in these phases and decreasing during the final phase of therapy. Re-conceptualization and performing change IMs, the two types that presented statistical differences between groups, emerge during the intermediate phase showing an increasing tendency towards termination. The evidence presented by these studies on the IMs' development in EFT and CCT corroborates the model of narrative change presented by Matos and colleagues (2009), specifically concerning the relevance of re-conceptualization and performing change IMs. The similarities between NT, EFT and CCT suggest a common pattern of novelties' development in brief therapy. The three first IM types to emerge, action, reflection and protest, constitute without doubt narrative novelties in contrast with the problematic self-narrative. Regardless, they don't seem a sufficient attainment for the client to forge a preferred self-narrative since these types are also what characterizes the poor outcome group. Re-conceptualization and

performing change IMs seem to play a crucial role in the construction of a new and sustained self-narrative. Re-conceptualization IMs enable the development of the clients' sense of authorship once they achieve a self-empowered position that allows them to be the authors of their own self-narrative. As several theorists have pointed out the unfolding of this sense of authorship is related to the unfolding of therapeutic change (e.g. Angus & Mcleod, 2004). In this sense, re-conceptualization IMs constitute a core type for the development of sustained change since they articulate the present self with the past problematic self-narrative, positioning the client as the author of his or her own experience and organizing the most elementary novelties that are elaborated in the form of action, reflection and protest IMs into a coherent new self-narrative. Re-conceptualization IMs involve the client's metaposition over the change process, and this metaposition allows the client to see his or her own transformation from the past to the present self (Gonçalves et al., 2009). This ability to decenter from the problematic self-narrative and focus on new self-positions gives the client the sense of authorship claimed by several authors to be critical in therapeutic change (Dimaggio, Salvatore, Azzara, & Catania, 2003; Hermans, 2006). As claimed by Beitman, Soth and Bumby (2005) "*Most psychotherapy requires clients to "step back" to observe and describe the landscapes of their minds. This ability provides a sense of agency, an "I", observing, planning, deciding, and evolving toward a future goal.*" (p.67). This is the essence of re-conceptualization.

Performing change IMs promotes the anchoring of the present self-narrative emergent in re-conceptualization IMs into the future. This is why they tend to emerge after re-conceptualization, characterizing the last sessions of therapy, just before its end.

I will now focus on the differences of the IM development in the analysed therapeutic models, EFT and CCT, in this dissertation, and also contrasting with NT.

Both EFT and CCT present almost total absence of action IMs in both outcome groups and also a lower value of performing change IMs when compared to NT. As explored in the discussion of the second chapter we hypothesize that this is related with the theoretical assumptions underlying the different therapeutic modalities. In a single case-study (Santos, Gonçalves, Matos, & Salvatore, 2009), the 5 IMs types were aggregated in two distinct dimensions, by using cluster analysis and binary correspondence analysis. Action and performing change IMs were gathered around an acting cluster and reflection, protest and re-conceptualization IMs were clustered into a cluster of meaning. This can be a possible account for these differences since EFT and CCT underlie a humanistic base. Both models emphasize therapist empathic understanding towards the clients' elaboration and exploration, validating their idiosyncrasy and their experience moment by moment (Goldman, Greenberg, & Pos, 2005; Greenberg &Watson, 1998). In this sense these modalities give more attention to the meaning side of the client's experience instead of their concrete behaviors outside the therapeutic context.

Taking into consideration the differences between EFT and CCT explored in the third study, EFT presents a marginally higher overall textual salience of IMs than CCT but, when considering the subsamples of the outcome groups (good vs. poor) no differences were found. When considering the differences between EFT and CCT regarding the five IMs types, the difference lies in protest IMs. As it is explored in the fourth chapter, protest IMs emerge mainly in the context of two-chair and empty-chair dialogues. So, since EFT involves the adding emotion-focused interventions to client-centered relational conditions it is not surprising that protest IMs is significantly higher in this therapeutic model. Furthermore, Watson and Greenberg (1996) found that empty-chair and two-chair dialogues are related to deeper emotional-processing and

better outcome which may corroborate our finding of higher values of IMs in EFT and protest IMs as a route to self-narrative reconstruction.

The first three chapters of this dissertation accomplish their goal to give support to the narrative model of change through the analyses of therapeutic cases with the IMCS. We may now speculate that this model might describe a common path in brief successful psychotherapy. The IM development is similar in three different samples and also in other therapeutic modalities studied through single case-studies (Alves et al, 2010; Ribeiro et al., 2009).

The fourth chapter of this dissertation entails a further development of the IMCS. In the single case-study of Lisa (first chapter) two subtypes (I and II) of reflection and protest IMs were underlined. Reflection IMs subtype I entails the client understanding of the problem, the emotional experience and the needs their emotions comprise, while subtype II is centered on the meanings that emerge around change. Protest IMs reveal the movement from a position of confront and critique (subtype I) into a position of assertiveness and agency (subtype II) in which the client repositions him or herself in opposition of the assumptions (or rules) of the problematic narrative. This last study followed the intention to investigate if these subtypes would emerge in the other cases that constituted our EFT sample. In fact, we found that these subtypes can be reliably identified and also significant differences were found concerning the subtype II of both reflection and protest IMs. These statistical differences present in reflection and protest IMs highlight qualitative differences embedded in these types since no quantitative differences were displayed in previous studies (Matos et al., 2009; chapter 2 and 3 of the present dissertation). We hypothesize that self-narrative transformation is facilitated through further elaboration and expansion of subtype I to subtype II of both reflection and protest IMs. Reflection subtype II exhibits an increasing trend from the beginning

until the end of therapy in both groups but is significantly higher in the good outcome group. Akin to reflection IMs, only subtype II of protest IMs presented statistical differences between groups being higher in the good outcome cases. Protest subtype II displayed a developmental line of an U-inverted, increasing until middle therapy and decreasing in the final phase. We speculated that this decreasing of protest subtype II is associated with the increasing trend of re-conceptualization IMs during the intermediate phase towards termination (see chapter 2). We assume that the new views of self elaborated in re-conceptualization IMs constitute an extension and consolidation of the empowered positions that emerge during the elaboration of protest IMs subtype II. The new self-positions that emerge also in the form of reflection subtype II may serve as scaffolding for the development re-conceptualization IMs. Subtypes II defy the problematic prior self-organization and the further elaboration on these narrative novelties facilitates re-conceptualization IMs. Through this type of IMs we can observe the clients' expression of "*a sense of multiplicity and mutability in selfhood that can foster significant life revision and change*" (Neimeyer, 2006, p.112) prompting clients into the authorship of a new and preferred self-narrative.

To sum up, reflection and protest IMs create novelty in the former self-organization and the subsequent cycles of blended IMs continue to validate these new feelings, new resilient responses and the emerging self-organization that appear embedded in re-conceptualization IMs. We believe that re-conceptualization depicts an enduring change of the new self-organization, reflection depicts change in momentary state and protest constitutes the meaning bridge between them. Performing changes IMs enable the future of the new self-narrative, authoring the consequences of change, since they represent new skills and behaviors being implemented outside therapy, in everyday life.

As a final point, I will elaborate on a "meaning-bridge" between the IMs and the general model of the change process in process-experiential intrapersonal tasks (Elliot & Greenberg, 1997; Elliott, Watson, Goldman, & Greenberg, 2004) that involves 6 stages. EFT is a therapeutic modality that privileges the work with emotions, considering them as the driving force for change and meaning-making. This therapeutic model entails the client-centered relational conditions with empathic attunement as its cornerstone and process-experiential tasks as focusing for an unclear felt sense, systematic evocative unfolding for problematic reactions, two-chair dialogue for conflict splits and empty chair dialogue for unfinished business (Elliott et al., 2004; Greenberg, Rice, & Elliott, 1993; Greenberg & Watson, 2006). Much of EFT centers around these tasks and for that reason Elliott and Greenberg (1997) constructed a model to describe the client's process of change through the intrapersonal tasks, from finding a marker which consists in the expression of a certain difficulty to the full resolution of the task. From the moment the marker is established (stage 1) the therapist facilitates the emotional evocation of the client's difficulty (stage 2). Further exploration and deepening of the difficulty (stage 3) is needed to access primary emotions and underlying emotion schemes. As they enter the transformation phase that can go from partial resolution (stage 4) to resolution (stage 5) and the optimal result of full resolution of that difficulty (stage 6). If applying this general model of change to the IMs we would start with stage 3 because stage 1 and 2 are still in the domain of the problematic self-narrative. The deepening through dialogical exploration between client and therapist or between parts of the self in stage 3 may facilitate, through the exploration and deepening of the self and inner processes, the emergence of reflection and protest subtypes I. These first forms of innovation may also produce, after its emergence, a return to the problematic self-narrative as this is a stage where clients

become stuck and may fail the resolution. Stage 4 entails clients' access to new aspects of experiencing intending to reach core needs and values which is related with reflection and protest subtypes II elaboration. Re-conceptualization IMs are associated with restructuring and scheme change (stage 5) through client's awareness, understanding and positive re-evaluation and empowerment. Performing change IMs are related with stage 6 that entails the carrying forward of client's implications of change into extratherapy changes.

Reflecting upon the results of the studies that comprise this dissertation we may assume that the IMs' development seems a core ingredient, shared by different therapeutic modalities, of successful brief psychotherapy which is consistent with the theory of common factors (Norcross & Goldfried, 2005; Duncan, Miller, Wampold, & Hubble, 2010). In addition, the empirical support given to the IMCS assures this coding system as a reliable and transtheoretical methodological tool to identify innovations in psychotherapy. The IMCS is a method for comprehensive process analysis of important moments of therapy.

Taking into account the implications for clinical practice I consider that as outcome measures inform therapists of the ongoing therapeutic process also process measures can inform therapists of the change process that is taking place in the therapeutic case. These in-session events may depict the change process throughout therapy but the purpose and meaning of these narrative innovative details are "often not apparent at the time they are told" (Stiles, Honos-Webb, & Lani, 1999, p.1218). Hence, helping therapists to pay attention to IMs and to subsequently draw their therapeutic efforts in their expansion can foster the process of meaning-making, promoting self positions of self-assertion, agency, and empowerment and consolidate the development of a new preferred view of self.

Considering the low proportion of performing change IMs in both EFT and CCT, when compared to NT, I also suggest that these therapeutic models could give more emphasis to the role that the new versions of the self play in the daily life. Since narratives are grounded in experience, therapist could also explore the experience of the new self outside the therapeutic context. As several authors pointed out a new self-narrative has to have a future (Crites, 1986; Omer & Alon, 1997; Slusky, 1998).

Taking into consideration new paths for future research I suggest to continue the study of the IMs developmental pattern in other therapeutic models in order to find if the same developmental pattern is found in good and poor outcome cases, for example, cognitive therapy or psychoanalysis, since the samples studied so far, although different they all rely on a constructivism framework. Being the small size of both samples of EFT and CCT one of the major limitations of the studies presented I encourage including more cases from both models in order to endorse the results of these studies.

Usually, IMs are defined as being both markers of change and processes of change but we have no empirical evidence to support our hypothesis of IMs as processes of change; they could just be outcome variables. This is an imperative topic to address in future research (Kazdin, 2009).

Since the collaborative work of the therapist and the client constitutes one common factor in psychotherapy (Duncan, et al., 2010) and since therapy is a flow of unfolding speaking turns between therapist and clients, I suggest including the therapist in this depiction of the analyses of the process of change with the IMCS. How the therapist helps the client to elaborate an IM and how they further expand these therapeutic innovations? This can be studied through conversation analysis using single case-studies, analysing the moments that precede the elaboration of the IMs. Single case-studies could be also recommended to better understand the role of re-conceptualization

IMs. Given that one of the major findings of this dissertation concerns the crucial role of this IM type in the construction of change in psychotherapy, I propose the study of each re-conceptualization IMs in one therapeutic case and the analysis of their narrative elaboration across sessions, in order to investigate how they organize the other IMs types, like action, reflection and protest, or how these IMs types help the scaffolding of meaning-making grasped in re-conceptualization IMs.

In the domain of psychotherapy research is essential the study of productive and unproductive client processes in therapy. If we consider IMs as productive moments in therapy we should also study the unproductive moments (e.g., the moments in which the therapist is eliciting an IM and the client aborts this effort by the therapist) to help us understand what is maintaining clients stuck in their self-problematic narrative impeding them to develop and evolve.

REFERENCES

REFERENCES

Alves, D., Mendes, I., Neimeyer, R., & Gonçalves, M. (2010). Innovative moments and change in constructivist grief psychotherapy: The case of Cara. Manuscript in preparation.

Angus, L., Goldman, R., & Mergenthaler, E. (2008). Introduction. One case, multiple measures: An intensive case-analytic approach to understand client change processes in evidence-based, emotion-focused therapy of depression. *Psychotherapy Research, 18*, 629-633.

Angus, L., Levitt H., & Hardtke, K. (1999). The narrative processes coding system: Research applications and implications for psychotherapy practice. *Journal of Clinical Psychology, 55*, 1255 – 1270.

Angus, L., & McLeod, J. (Eds.) (2004). *The handbook of narrative psychotherapy: Practice, theory and research*. London: Sage.

Baerger, D. R., & McAdams, D. (1999). Life story coherence and its relation to psychological well-being. *Narrative Inquiry, 9*, 69-96.

Beck, A. T. (1976). *Cognitive therapy and emotional disorders.* New York International Universities Press.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*, 77-100.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Beitman, B. D., Soth, A. M., & Bumby, N. A. (2005). The future as an integratating force through the school of psychotherapy. In J. C. Norcross & M. R. Goldfried

(Eds.), *Handbook of psychotherapy integration (2nd Ed.)* (65 - 83). New York: Oxford University Press

Botella, L., Herrero, O., Pacheco, M., & Corbella, S. (2004). Working with narrative in psychotherapy: A relational constructivist approach. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory and research* (pp. 119–136). London: Sage.

Brinegar, M. G., Salvi, L. M. and Stiles, W. B. (2008). The case of Lisa and the assimilation model: The interrelatedness of problematic voices. *Psychotherapy Research, 18,* 657-666.

Bruner, J. (2004). The narrative creation of the self. In L. E. Angus & J. McLeod (eds.), *The handbook of narrative psychotherapy: Practice, theory and research* (pp. 3 - 14). London: Sage

Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, MA: Harvard University Press.

Cook, T. D., & Campbell, D. T. (1979). Quasi-experimentation: Design and analysis issues for field settings. Boston, MA: Houghton Mifflin Company.

Crites, F. (1986). Story time: Recollecting the past and projecting the future. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of conduct* (pp. 152-173). New York: Praeger.

Dimaggio, G. (2006). Disorganized narratives in clinical practice. *Journal of Constructivist Psychology, 19*, 103-108.

Dimaggio, G., Salvatore, G., Azzara, C., & Catania, D. (2003). Rewriting self-narratives: The therapeutic process. *Journal of Constructivist Psychology, 16*, 155–181.

Drozd, J. F., & Goldfried, M. R. (1996). A critical evaluation of the state-of-art in psychotherapy outcome research. *Psychotherapy, 33*, 171-180.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.) (2010). *The heart and soul of change: Delivering what works*. Washington: American Psychological Association.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20*, 123 – 135.

Elliot, R., & Greenberg, L. S. (1997). Multiple voices in process-experiential therapy: Dialogues between aspects of the self. *Journal of Psychotherapy Integration, 7*, 225 - 239.

Elliott, R., Watson, J. C., Goldman, R., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: the process-experiential approach to change*. Washington, DC: American Psychological Association.

Fife-Schaw, C. (2006).Levels of measurement In G. M. Breakwell, S. Hammond, C. Fife-Schaw, & J. A. Smith (Eds), *Research methods in psychology* (3rd Ed.). London: Sage.

Gendlin, E. T. (1981). *Focusing* (2nd Ed.). New York: Bantam Books.

Goldman, R. N., Greenberg, L. S., & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research, 15*, 248 – 260.

Gonçalves, M.M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology, 22*, 1–23.

Gonçalves, M. M., Mendes, I., Cruz, G., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Narrative change in client-centered therapy and emotion-focused therapy: A comparative study. Manuscript in preparation.

Gonçalves, M. M., Mendes, I., Ribeiro, A., Angus, L., & Greenberg, L. (2010). Innovative moments and change in emotional focused therapy: The case of Lisa. *Journal of Constructivist Psychology, 23,* 1 - 28.

Gonçalves, M. M., Ribeiro, A., Matos, M., Santos, A., & Mendes, I. (2010). The Innovative Moments Coding System: A new coding procedure for tracking changes in psychotherapy. In S. Salvatore, J. Valsiner, S. Strout, & A. Gennaro (Eds.), *YIS: Yearbook of Idiographic Science 2009 - Volume 2*. Rome: Firera Publishing Group.

Gonçalves, M. M., Santos, A., Matos, M., Salgado, J., Mendes, I., Ribeiro, A., Cunha, C. & Gonçalves, J. (2010). Innovations in psychotherapy: Tracking the narrative construction of change. In J. D. Raskin, S. K. Bridges, & R. Neimeyer (Eds.), *Studies in meaning 4: Constructivist Perspectives on Theory, Practice, and Social Justice* (pp. 29 - 64). New York: Pace University Press.

Gonçalves, O. F., & Machado, P. P. P. (1999).Narrative in Psychotherapy: The Emerging Metaphor [Special issue]. *Journal of Clinical Psychology, 55*, 1175-1177.

Greenberg, L. S. (1986). Change Process Research. *Journal of Consulting and Clinical Psychology, 54*, 4-9.

Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association.

Greenberg, L. S., & Angus, L. E. (1994). *How therapy works*. Social Sciences and Humanities

Greenberg, L. S., Auszra, L., & Herrmann, I. R. (2007). The relationship among emotional productivity, emotional arousal and outcome in experiential therapy of depression. *Psychotherapy Research, 17*, 482–493.

Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process*. New York: Guilford.

Greenberg, L.S., Rice, L., & Watson, J. (1994). *Manual for client-centered therapy*. Unpublished manuscript. York University, Toronto.

Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client–centered relationship conditions and process interventions. *Psychotherapy Research, 8,* 210–224.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-Focused Therapy for Depression*. Washington: American Psychological Association.

Habermas, T., & Bluck, S. (2000). The life story schema. *Motivation and Emotion, 24,* 2, 121 - 147.

Hastie, T., & Tibshirani, R. (1990). *Generalized additive models, Volume 43 of Monographs on statistics and applied probability*. London: Chapman & Hall.

Hermans, H. J. M. (2006). The self as a theater of voices: Disorganization and reorganization of a position repertoire. *Journal of Constructivist Psychology, 19,* 147 – 169.

Hermans, H. J. M. (2003). The construction and reconstruction of a dialogical self. *Journal of Constructivist Psychology, 16,* 89–130.

Hermans, H. J. M., & Hermans-Jansen, E. (1995). Self-narratives: The construction of meaning in psychotherapy. New York: Guilford.

Hill, C. E., & Lambert, M. J. (2004). Methodological issues in studying psychotherapy processes and outcomes. In M. J. Lambert, (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change (5th Ed.)* (pp. 84 - 135). New York: Wiley.

Honos-Webb, L., & Stiles, W. B. (1998). Reformulation of assimilation analysis in

terms of voices. *Psychotherapy Research, 7,* 23–33.

Honos-Webb, L., Stiles, W. B., Greenberg, L. S., & Goldman, R. (1998). Assimilation analysis of Process-Experiential Psychotherapy: A comparison of two cases. *Psychotherapy Research, 8,* 264-286.

Jacobson, N.S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12–19.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19,* 418 – 428.

Keele, L. (2008). *Semiparametric regression for the social sciences*. New York: John Wiley and Sons.

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.

Kendall, P., & Holmbeck, G., & Verduin, T. (2004).Methodology, design, and evaluation in psychotherapy research In M. J. Lambert (Eds), *Bergin and Garfield's handbook of psychotherapy and behavior change (5th ed.)* (pp. 16-43) New York: John Wiley & Sons.

Knox, S., Hill, C. E., Hess, S. A., & Crook-Lyon, R. E. (2008). Case studies of the attainment of insight in dream sessions: replication and extension. *Psychotherapy Research, 18,* 200-215.

Lambert, M. J. (2004). *Bergin and Garfield's Handbook of psychotherapy and behavior change (5th Ed.).* United States: John Wiley and Sons.

Lutz, W., & Hill, C. E. (2009). Quantitative and qualitative methods for psychotherapy research: Introduction to special section. *Psychotherapy Research, 19,* 369 – 373.

Mahoney, M. (1991). *Human change processes: The scientific foundations of psychotherapy.* New York: Basic Books.

Matos, M., Santos, A., Gonçalves, M. M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research, 19,* 68-80.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.

McAdams, D. P. (2001a). *The person: An integrated introduction to personality psychology*. Orlando, Fl.: Harcourt.

McAdams, D. P. (2001b). The psychology of life stories. *Review of General Psychology, 5,* 100-122.

McGlinchey, J.B., Atkins, D.C., & Jacobson, N.S. (2002). Clinical significance methods: Which one to use and how useful are they? *Behavior Therapy, 33,* 529–550.

McLeod, J. (2004). Social construction, narrative, and psychotherapy. In L. E. Angus & J. Mcleod (eds.), *The handbook of narrative psychotherapy: Practice, theory and research* (pp. 351 - 365). London: Sage

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., Gonçalves, M. (in press). *Narrative Change in Emotion-Focused Therapy: How is change constructed through the lens of the Innovative Moments Coding System?* Psychotherapy Research.

Mendes, I., Ribeiro, A., Angus, L., Greenberg, L., Sousa, I., & Gonçalves, M., (2010). *Narrating Innovative Moments in Emotion-Focused Psychotherapy: A study on the developmental processes in the construction of a new self-narrative.* Manuscript in preparation.

Neimeyer, R. A. (2006). Narrating the dialogical self: Toward an expanded toolbox for the counseling psychologist. *Counselling Psychology Quarterly, 19,* 105-120.

Nicolò, G., Dimaggio, G., Procacci, M., Semerari, A., Carcione, A., & Pedone, R. (2008). How states of mind change in psychotherapy: An intensive case analysis of Lisa's case using the Grid of Problematic States. *Psychotherapy Research, 18,* 645-656.

Norcross, J. C., & Goldfried, M. R. (2005). *Handbook of psychotherapy integration*. New York: Oxford University Press.

Omer, H., & Alon, N. (1997). *Constructing therapeutic narratives*. Northvale, N. J.: Jason Aronson.

Osatuke, K., & Stiles, W. (2006). Problematic internal voices in clients with borderline features: An elaboration of the assimilation model. *Journal of Constructivist Psychology, 19,* 287–319.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany: State University of New York Press.

Polkinghorne, D. E. (2004). Narrative therapy and postmodernism. In L. E. Angus & J. Mcleod (Eds.), *The handbook of narrative psychotherapy: Practice, theory and research* (pp. 53 - 67). London: Sage

Prochaska, J. O., & Norcross, J. (2001). Stages of change. *Psychotherapy, 38,* 443-448.

Ribeiro, A.P., Gonçalves, M. M., & Ribeiro, E. (2009). Processos narrativos de mudança em psicoterapia: Estudo de um caso de sucesso de terapia constructivista [Narrative change processes in psychotherapy: A case-study of successful constructivist therapy]. *Psychologica, 50, 181-203.*

Ribeiro, A., Gonçalves, M.M., & Santos, A. (in press). Innovative moments in psychotherapy: From the narrative outputs to the semiotic-dialogical processes. In S. Salvatore, J.Valsiner, S. Strout, & J. Clegg (Eds.), YIS: Yearbook of Idiographic Science 2010 – Volume 3. Rome: Firera & Liuzo.

Rice, L. N., & Greenberg, L. S. (Eds.). (1984). *Patterns of change*. New York: Guilford Press.

Rogers, C. R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.

Rogers, C. R. (1975). Empathic: an unappreciated way of being. *The counselling Psychologist*, *5* (2), 2-11.

Santos, A., Gonçalves, M. M., & Matos, M. (2010). Innovative Moments and Poor-outcome in Narrative Therapy. Counselling and Psychotherapy Research. DOI: 10.1080/14733140903398153

Santos, A., Gonçalves, M. M., Matos, M., & Salvatore, S. (2009). Innovative moments and change pathways: A good outcome case of narrative therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 82, 449-466.

Sarbin, T. R. (1986). The narrative and the root metaphor for psychology. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 3–21). New York: Praeger.

Semerari, A., Carcione, A., Dimaggio, G., Faclone,M., Nicolo, G., Procacci, M., et al. (2003). The evaluation of metacognitive function in psychotherapy: The metacognitive assessment scale and its applications. *Clinical Psychology and Psychotherapy*, *10*, 238–261.

Slusky, C. E. (1998). Strange attractors and the transformation of narratives in family therapy. In M. F. Hoyt (Ed.), *The handbook of constructive therapies: Innovative approaches from leading practitioners* (pp. 159-179). San Francisco: Jossey-Bass.

Spitzer, R., Williams, J., Gibbons, M., & First, M. (1989). *Structured clinical interview for DSM-III-R*. New York: American Psychiatric Press.

Stiles, W. B. (2003). When is a case study scientific research? *Psychotherapy Bulletin*, *38*, 6-11.

Stiles, W. B. (2005). Case studies. In J. C. Norcross, L. E. Beutler & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 57-64). Washington, DC: American Psychological Association.

Stiles, W. B. (2006). Assimilation and the process outcome: Introduction to a special issue. *Psychotherapy Research, 16,* 389–392.

Stiles, W. B. (2007). Theory-building case studies of counselling and psychotherapy. *Counselling and Psychotherapy Research, 7,* 122–127.

Stiles, W. B., Honos-Webb, L., & Lani, J. A. (1999). Some functions of narrative in the assimilation of problematic experiences. *Journal of Clinical Psychology, 55,* 1213-1226.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). "Are all psychotherapies equivalent?". *American Psychologist, 41*, 165-180.

The Case of Lisa [Special Section] (2008). *Psychotherapy Research, 18* (6).

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. NJ: Lawrence Erlbaum.

Watson, J. C., & Greenberg, L. S. (1996). Pathways to change in psychotherapy of depression: Relating process to session change and outcome. *Psychotherapy Research, 33,* 262 – 274.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.

White, M. (2007). *Maps of narrative practice*. New York: Norton.

APPENDIX I

INNOVATIVE MOMENTS CODING SYSTEM

INNOVATIVE MOMENTS CODING SYSTEM

Version 7.2

Miguel M. Gonçalves, Marlene Matos, & Anita Santos

University of Minho, January 2009

Innovative Moments Coding System (IMCS) is a procedure of qualitative analysis. Data must be of qualitative type and the analysis procedure obeys the inferential principle of categories inclusion. Therefore, content analysis of data is performed by Innovative Moments (IMs) categories. The System is open ended, allowing new conceptualizations derived from data analysis.

1. Innovative Moments definition

An Innovative Moment (IM) refers to the emergence of something outside the problem saturated story, different from what is usually narrated by the client (White & Epston, 1990). This can be a feeling, a thought, an episode or even a project not predicted by the problem saturated story. Consequently, an IM is, necessarily, a narrative novelty.

1.1 Principles

Innovative Moments notion emerges from the re-authoring model proposed by White and Epston (1990), and refers to what these authors assigned as "unique outcome". According to narrative therapy (White & Epston, 1990), the constructions of new and alternative narratives are the result of the elaboration of unique outcomes; these are considered openings to new narratives, or opportunities so that therapeutic change can happen. They emerge during therapeutic conversation, although being trivialized or unacknowledged when problem saturated stories are dominant.

The denomination of "unique" does not refer to a judgemental frequency (e.g., in the sense that appears only once), but to the contrast with the problem ("unique" from the point of view of the problem). The term outcome also does not refer to a therapeutic outcome, but an emphasis is placed on process dimensions of change. Innovative

Moments entail a dynamic, process and a multiple nature. They enable small but significant changes that constitute markers of narrative development of novelty (Gonçalves, Matos & Santos, in press). Thus, in our coding system, we choose to refer to unique outcomes as innovative moments.

2. Applicability

IMCS aims to allow the understanding of change processes beneath different life situations that are under study (therapeutic change, non therapeutic change, life transitions, new health situation adaptation…). IMCS applies to qualitative data, namely discourse or conversation, as therapeutic sessions, qualitative/in depth interviews, biographies, predominantly in video systems or transcripts.

3. Dimensions of analysis:

3.1 Types of IM: Action, Reflection, Protest, Reconceptualization and New Experiences (see table 1).

3.1.1 Table 1 - Innovative Moments Grid

Types of IM	Subtypes	Contents
Action IM (A) Actions or specific behaviours against the problem(s).		New coping behaviours facing anticipated or existent obstacles Effective resolution of unsolved problem(s) Active exploration of solutions Restoring autonomy and self-control Searching for information about the problem(s)

Reflection IM (R) Thinking processes that indicate the understanding of something new that makes the problem(s) illegitimate (e.g., thoughts, intentions, interrogations, doubts).	(i) Creating distance from the problem (s)	Comprehension – Reconsidering problem(s)' causes and/or awareness of its effects New problem(s) formulations Adaptive self instructions and thoughts, Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being
	(ii) Centered on the change	Therapeutic Process – Reflecting about the therapeutic process Change Process – Considering the process and strategies implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change). New positions – references to new/emergent identity versions in face of the problem(s).
Protest IM (P) Moments of critique, that involve some kind of confrontation (directed at others or versions of oneself); it could be planned or actual behaviours, thoughts, or/and feelings.	(i) Criticizing the problem(s)	Position of critique in relation to the problem(s) or/and the others who support it. The other could be an internalized other or facet of oneself.
	(ii) Emergence of new positions	Positions of assertiveness and empowerment Repositioning oneself towards the problem(s)
Re-conceptualization IM (RC) Process description, at a meta-cognitive level (the client not only manifests thoughts and behaviours out of the problem(s) dominated story, but also understands the processes that are involved in it). In case the RC includes NE we should code RC with NE (RCNE)[5].		RC always involve two dimensions: A. Description of the shift between two positions (past and present) and B. the process underlying this transformation.
Performing Change IM (PC) References to new aims, experiences, activities or projects, anticipated or in		Generalization into the future and other life dimensions of good outcomes Problematic experience as a resource to

[5] For the sake of the analysis of the saliency we should consider RC.

action, as consequence of change.		new situations Investment in new projects as a result of the process of change Investment in new relationships as a result of the process of change Performance of change: new skills Re-emergence of neglected or forgotten self-versions

3.1.2 Differentiating IMs

Action IMs – Actions or specific behaviours against the problematic story. They should not be the result or a direct consequence of the problem, but they should lead to the potential creation of new meanings. Thus, for instance, to protect myself instinctively from an aggression is not an IM. But, to protect myself in a more intentional way, is considered an IM (e.g., leaving home or asking for help).

Clinical vignette[6]

T (therapist): Was it difficult for you to take this step (not accepting the rules of "fear" and going out)?

C (client): Yes, it was a huge step. For the last several months I barely got out. Even coming to therapy was a major challenge. I felt really powerless going out. I have to prepare myself really well to be able to do this.

Reflection IM – Emergence of new understandings or thoughts that do not legitimate the problem or are not congruent with the dominant plot. According to

[6] The clinical vignettes were published in Gonçalves, Matos, & Santos (2009).

Bruner (1986), a good story implies the landscape of action and consciousness. IM Reflection relates to the landscape of consciousness, to the way a person feels, knows and thinks. On the other hand, the landscape of action includes the setting, the actors and the actions (usually present in action and protest IM). Reflection IMs does not imply defiance by the individual towards someone or to the community/society, which represents/entails a position that supports the problem, like it happens in the protest IM.

Note: Whenever possible, Action and Reflection IMs should be coded separately (e.g. "I left home for the first time [Action IM] and I felt good. [Reflection IM]"). When the client/interviewee is reflecting about specific actions, we should code Reflection (e.g. "Leaving home for the first time made me feel great!")

Clinical vignette

C: I'm starting to wonder about what my life will be like if I keep feeding my depression.

T: It's becoming clear that depression had a hidden agenda for your life?

C: Yes, sure.

T: What is it that depression wants from you?

C: It wants to rule my whole life and in the end it wants to steal my life from me.

Protest IM – moments of protest**,** defiance or attitudinal divergence, which can involve actions, thoughts and feelings, projected or accomplished.

Assumes the presence of two positions: one that legitimates or supports the problem (entailed by a person or by a given society or culture), and another one that defies or confronts the first one. It involves proactivity and personal agency by the client.

IMs of reflection and protest differentiate themselves by the internal positioning of the first ones, of considering alternatives (e.g., "*I believe I found a solution*"), of questioning (e.g., "*I'm wondering if something can justify that …?*"). However, protest IM can also involve thoughts or feelings, but it is a way of repositioning the self through a proactive, categorical, affirmative or assertive process (e.g., "*I think that nothing can justify this; I decided that I won't allow fear to interfere in my life any more*"). They involve a repositioning towards the problem and its effects, as well as to the others that eventually legitimate the problem (e.g., *"I told my mother that I won't accept her ideas about my marriage!").*

Clinical vignette

C: I talked about it just to demonstrate what I've been doing until now, fighting for it…

T: Fighting against the idea that you should do what your parents thought was good for you?

C: I was trying to change myself all the time, to please them. But now I'm getting tired, I am realising that it doesn't make any sense to make this effort.

T: That effort keeps you in a position of changing yourself all the time, the way you feel and think…

C: Yes, sure. And I'm really tired of that, I can't stand it anymore. After all, parents are supposed to love their children and not judge them all the time.

Re-conceptualization IM – implies a kind of meta-reflection level, from where the person not only understands what is different in her/him, but is also able to describe the processes involved in the transformation.

This meta-position enables to access the self in the past (problematic narrative), the emerging self, as well as the description of the processes that allowed the transformation from the past to the present. While reflection IMs are related to novelty in terms of a thinking *episode* or *moment* (related to the past, present or future) that is outside the prescription of the dominant story, reconceptualization IMs are associated with the narration of a meta-reflection *process* involved in change. The perception of some transformation is narrated, making clear (1) the process involved in its emergence and (2) the distinction between that moment and the former condition. These two elements must be distinct. Thus, as an example, when the client says "now I'm more responsible", this is not by itself a reconceptualization IM. To do so, another element has to be present, like "now I'm more responsible and that allows me X or Z" (X or Z not being a mere description of responsibility). Therefore, the element associated to the process of change cannot be exactly the same as the transformation (e.g., "more patient" and I've learned to be more patient). Nevertheless, this contrast between past self and emerging/changing self can appear implicitly [e.g. "I am <u>more</u> mature now (than in the past)"], as long as this is clearly distinct from the transformation process.

Note: In case of doubt between a Re-conceptualization IM and a Reflection II IM, we should be more conservative and code Reflection II.

<u>Clinical vignette (victim of partner abuse)</u>

C: I think I started enjoying myself again. I had a time… I think I've stopped in time. I've always been a person that liked me. There was a time… maybe because of my attitude, because of all that was happening, I think there was a time that I was not respecting myself… despite the effort to show that I wasn't feeling… so well with

myself… I couldn't feel that joy of living, that I recovered now… and now I keep thinking "you have to move on and get your life back".

T: This position of "you have to move on" has been decisive?

C: That was important. I felt so weak at the beginning! I hated feeling like that…. Today I think "I'm not weak". In fact, maybe I am very strong, because of all that has happened to me, I can still see the good side of people and I don't think I'm being naïve… Now, when I look at myself, I think "no, you can really make a difference, and you have value as a person". For a while I couldn't have this dialogue with myself, I couldn't say "you can do it" nor even think "I am good at this or that"…

Performing Change IMs – these IMs refer to the anticipation or planning of new experiences, projects or activities at personal, professional and relational levels. They also can reflect the performance of change or new skills that are akin to the emergent narrative (e.g., new projects that derive from a new self version). They describe the consequences of the change process, for instance acquire new understandings that are useful for the future or assuming him/herself as an experiential expert, referring which new skills are acquired after overcoming the problematic experience.

The codification of new experiences implies the presence of an implicit or explicit marker of change, i.e., the client narrates the perception of some transformation.

Clinical vignette

T: You seem to have so many projects for the future now!

C: Yes, you're right. I want to do all the things that were impossible for me to do **while I was dominated by fear** [marker of change]. I want to work again and to have the time

to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.

Nevertheless, the contrast between past self and emerging/changing self can be also stated by the therapist and accepted by the client.

Clinical vignette

T: I believe Maria is much closer to what you would like than in the beginning…

C: Yes, no doubt about it! [marker of change]

T: T: What is it that it's still missing? New targets?

C: I want to get solid… in this last times, I've really made up my mind to achieve targets: the relationship with my boyfriend, the relationship with my father…

Differentiating New Experiences from Reflection:

- If the client narrates a vague desire to change (e.g., "there is so much thing that I still I want to change in my life!") one should code it as a reflection, even if we are able to recognize that this goal is a clear consequence of the change process.

- We have stated elsewhere that new experiences can be a performance of change or new skills that are akin to the emergent narrative. These kind of new-experiences implies not only a reflection about the change (e.g., "now I'm more assertive than I was in the past"), but also the narration of a specific episode (performance) that mirrors it.

Clinical vignette

C: I was able to actually bring up the subject and talk to my husband about it, **as before in the past** [marker of change], like I was afraid to say something because he'd take it the wrong way, and he'd take it as though I'm sort of attacking him, that he's lazy or not working hard enough, or whatever…

T: so you're feeling kind of more freed up, it sounds…

C: yes…

T: like to be able to bring up things with him…

C: mm-hm…

T: and talk about things a lot more, kind of less afraid, it sounds like - less cautious about approaching him…

C: mm-hm, right…

T: - it's kind of like you are freed up yourself…

C: mm-hm…

3.2 Subtype (see table 1)**:** regarding IMs of action, reflection and protest. These subcategories are based on the research conducted with the IMCS. After qualitative analysis, the researchers identified these subtypes in a consensual way.

3.3 Salience: percentage of time consumed by each IM in the session, related to total amount of time of the session (with transcripts the saliency could be measured by the quantity of text occupied by each IM, in reference to the full text).

3.4 Emergence: indicates if the IM is brought to the conversation by therapist/interviewer or the client/interviewed. Basically, there are three possibilities:

(1) the IM is produced by the therapist and accepted by the client; (2) the IM results from a therapist's question which clearly facilitates its emergence (e.g., T: What can you learn from this experience?; C: I learned that…[a specific IM]); (3) The IM is spontaneously produced by the client, not being triggered by any question made by the therapist. This topic should be coded after the codification of the IMs.

4. Coding procedures

Coding is done, preferentially, through video visualization of data, using the scoring sheet (attached) or the coding can be done using a software that allows video to be coded. Each session can be analyzed and reviewed; however when having several sessions they must be coded sequentially (only code the next one when the previous is completed).

5. Coding rules

1. It is recommended that coders read throughout the entire data (e.g., one entire session) to get acquainted with the material. In following readings coders should start coding the material, spending as much time as they think necessary. The initially coded IM could be revised in subsequent readings.

2. IMS can be coded whether in past, present and/or future time.

3. After an initial analysis of the sessions/interviews, raters must discuss about their comprehension of client's/ interviewee's problems. Thus, the innovative moments are identified based on this consensual definition of the problems. Subsequently, each rater identifies, throughout the sessions/interviews, all the problems mentioned by the

client/participant. The definition of the problems must be linked with the verbal material, i.e., close to client's/ interviewee's narrative, allowing the identification of the IMs in relation to it. Hence, the IM are coded with reference to a previous problem. For instance, the act of "*running away from the problem"* can be codified as an action IM if the problem is intimate abuse, even though an equivalent act can be part of the problem if we are talking about an anxiety disorder.

4. IMs emerge within a sequence that can be interrupted by the therapist. It is coded as the same IM, if within the same theme.

Example: multiple actions of personal protection (changing locks, coping documents) are Action IM in cases of partner abuse.

T: *You've done well. What about our arrangement about your safety?*

C: I've changed the locks, I've the phone numbers of…

T: *Emergency institutions*

C: *Emergency institutions****. I have it all. Documents… that doesn't worry me because I've my parents with me now, fortunately.***

T: *As you can see, you've had the system on your side, what doesn't always happen, but you had. You couldn't even return home today…*

C: I know

T: *As it happens in most cases. So documents would have been […] it wasn't important because […]*

C: I have them in the car. In that same day I have done copies at school because… school always has copies of all personal documents

T: *Besides changing locks, having your original documents, have you applied any other strategies? Another strategy was not returning home alone…*

C: That's right!

T:*You've done well.*

C: Even because I couldn't do it. I've called a neighbour to ask if she had seen anything and she told me that she hadn't seen anything.

5. IMs are defined as the emergence of something that is somehow new, even if the person states this novelty as a personal stable trait.

Example: "I'm not the kind of person that is influenced by fear"– the client has been influenced by fear many times before.

6. Protest can involve action or reflection, being coded protest whenever this situation applies.

7. After coding an excerpt where several IMs appear sequentially, the coder should re-read them to see if it is possible and adequate to aggregate them, evaluating if they are all part of a more complex IM.

Example:

C: ***You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…*** [At first sight – Re-conceptualization IM]

T: How did you have this idea of going to the museum?

C: ***I called my dad and told him: we're going out today*****!** [at first sight – Action IM]

T: This is new, isn't it?

C: Yes, it's like I tell you… I sense that I'm different… [at first sight – Reflection IM]

The coding should go like this:

C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…

T: How did you have this idea of going to the museum?

C: I called my dad and told him: we're going out today!

T: This is new, isn't it?

C: Yes, it's like I tell you… I sense that I'm different…

[Re-conceptualization IM]

8. When an overlapping of IMs occurs in the process of codification (in the same sentence or paragraph), we accept the following hierarchy (from the more basic to the more complex): 1. [action – reflection] – 2. [protest] – 3. [reconceptualization – new experiences], and consequently we code the most inclusive IM, that is the one considered hierarchically superior. So, when action and reflection are both present they are coded separately. When reconceptualization (RC) and new experiences (NE) occur overlapped we code the overlap coding RCNE. For purposes of salience we can

consider this mixture of RC and NE as RC (unless of course we have good reason to keep the code separated from "pure" RC)

Special considerations for salience measures

9. Beginning of an IM: IMs should be coded from the beginning of the grammatical sentence where the innovation content is appearing explicitly. (e.g. "Yesterday I went to the beach with my boyfriend and, / **for the first time in a long time I didn't feel depressed**. [Reflection IM]" – the slash signals a different thought.)

10. When an IM is questioned by the therapist, this question is not included when measuring salience; however, the therapist interventions are taken into account during the elaboration of an IM.

Example:

T: How did you feel this week?

*C: **I looked like someone else… everybody noticed that I was happier…***

*T: **And your happiness was reflected in what?***

*C: **Well… in everything… at work, at home…***

*T: **What, in your opinion, helped you feel that way?***

*C: **I think the most important thing was the conversation I had with my husband.*** [Reflection IM]

11. Likewise, when an IM is elaborated by the client, the first utterance of the therapist should be excluded, while the in-between turn-takings are included.

Example:

T: Susan, you look very different! It's shown in your posture… you look much more relaxed.

C: ***Yeah, absolutely.***

T: ***You're also much more at ease.***

C: ***Yes, I feel that also.*** [Reflection IM]

12. Length/Duration of an IM: If the client, while elaborating an IM, drifts away and changes the theme (e.g. making some commentaries about other things), this part of his speech is not included in the IM.

Example:

C: ***This week went very well… I went to the gym, also the theatre…*** *since it has been restored, they have been having different shows every week… I already knew that the director is not the same anymore. He's an old friend of my mother. My mother was born in X [place] and went to Y school, they were colleagues at school… I mean, then they drift away because of some quarrel – you know how that is like… friends are friends, but business apart.* ***Anyway, I had a great time, I could keep my mind away from the usual problems…*** [Do not code the underlined part]

Special cases for coding procedures in therapy

13. Regarding the empty chair task in psychotherapeutic processes:

i) IMs are only coded when client is talking in his/her own position, and not in someone else's position (father, mother …);

ii) IMs are coded when they refer to the critical self and experiential positions.

14. Usually, changes in relationships are coded as new experiences IMs (e.g., “we are getting closer”; “I’m giving more value to friendship”, etc.).

15. The reframing of difficult live events is, most of the time, coded as reconceptualization.

16. Negative changes are not identified as IMs.

6. Validity

Criterions of validity: exhaustively and mutual exclusion in IMs coding procedures.

7. Reliability

The coding requires a skilled rater, appropriately trained (who is expected to code the entire sample). Besides this, a second independent rater should be also called upon to code at least 30% of the sample, on the basis of which the percentage of agreement and the kappa of Cohen. Throughout this process, the pair of judges will meet regularly to conduct the reliability procedures specified before and to note differences in their perspectives of the problem and in their IMs coding (e.g. every 2 or 3 sessions coded). If these are detected, they are resolved through consensual discussion/coding.

If Cohen’s Kappa is lower than 0.75, the sample needs to be reviewed by an external and more experienced auditor. This auditor will look at disagreements that appeared in the material rated by the first pair of judges and review their differences, arriving at a final coding.

Session registry – Innovative Moments

CLIENT : _____ SESSION N.º _____ CODER : _____					
IM Type	Discursive marker	References (from the conversation)	Time (min. sec – min. sec.)	Time (sec.)	Emergence (C vs. T)
			-		